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“Have they got rehab potential?” – An ethnographic study exploring meaning and evaluations of rehabilitation potential for an older person following an acute admission

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“Have they got rehab potential?” – An ethnographic study exploring meaning and evaluations of rehabilitation potential for an older person following an acute admission

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ABSTRACT

Rehabilitation potential is the potential of an individual to benefit from interventions which aim to optimise and restore function after a period of ill-health or new onset of disability. Health professionals are frequently required to evaluate this potential to determine who may be most likely to benefit from the provision of ongoing rehabilitation services.

This doctoral study explored decision-making related to the assessment of rehabilitation potential of older people in hospital and the recommendation of rehabilitation pathways. To explore this in real-time, and in the shared patient and professional context in which decision-making occurred, principles of ethnographic and case-study research were utilised. The case study site was one acute medical ward within a local acute hospital in the North East of England. Three phases of fieldwork were undertaken, including a 2-week orientation and mapping phase, an 8 week period centred on the practice of occupational therapists and physiotherapists in relation to five patient cases, and finally a phase which involved five in-depth interviews with individual health professionals. Data was generated through observation, interviews and the review of clinical records. The whole data-set was analysed using thematic analysis.

Key findings highlight that rehabilitation in this context was understood as a process to facilitate physical improvements and associated with an organisational aim for optimum safety rather than optimum function. And, although idealised as a phase of care, rehabilitation was often linked to a specific place, with the evaluation of rehabilitation potential subsequently linked with a hospital transfer. Furthermore, rehabilitation potential was ambiguous and poorly explained to patients and families. Health professionals recognised that their evaluation of rehabilitation potential was linked to high-stakes decisions about access to, or withholding services, and therefore the

ethical dimensions of this decision had far-reaching influence. The involvement of the older person in judgements about rehabilitation potential and pathways was minimal, and there were many critical challenges to older people receiving fair and just access to services.

The research findings conclude that there are significant tensions between the context of acute hospital care and the philosophy and ideals of rehabilitation. Furthermore, findings can assist professionals to recognise and reconcile tensions in practice and to move towards reframing rehabilitation to place the individual needs of older people at the centre of service delivery.

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GLOSSARY

Acute Hospital – acute hospitals provide a range of services (including both physical and mental health services) which require time-sensitive and rapid intervention and are often orientated towards urgent or emergent episodes of injury or illness. In the United Kingdom, acute hospital care is a branch of secondary care (a level of care after the primary and most immediate care provider such as General Practitioner, Health Visitor or District Nurse) and often includes emergency and admission services, critical and intensive care and medical and surgical specialities. In this study, the acute hospital was a district hospital including some of these services and orientated towards physical health specialities.

Bio-medical Model – a term which is used to describe an approach to health care which focuses on the physical or biological aspects of disease and ill-health. It views the problems which arise from illness and disability as primarily related to the underlying disease pathology and therefore health interventions focus on these causes.

Gatekeeper – the term gatekeeper is used to describe those with control and decision-making authority about how tasks should be organised and by whom, and who often have responsibilities for access to resources. The term is used within the methodology section to discuss those with authority to enable researcher access to research resources such as sites and participants. The term is also used in the reporting of findings to represent health professionals with responsibility for access and referral to resources and services.

Health Professional – employed members of the NHS trust, registered with relevant regulatory bodies and who have direct responsibility for patient care. They include, for example, doctors, nurses, physiotherapists and occupational therapists. For the purpose this study, this term also may refer to social workers. The term is also used interchangeably with practitioners.

Occupational Therapist – registered health professionals who provide support for people to do everyday tasks, help people to regain or maintain independence where possible, and use everyday activity to promote health. Occupational therapists within this site provided assessment and interventions for older people who were experiencing changes in their abilities to carry out everyday activities following an acute hospital admission.

Pathway – a pathway, sometimes referred to as a care pathway or a patient pathway, is the route a patient takes when entering a healthcare system. In this research, the term pathway is used to refer to the journey from entry in to the acute hospital system for one episode of care. Although the term is sometimes used to refer to standardised tools to promote equity and consistency across a care delivery process, often for conditions with a predictable clinical course (for example hip fracture), the term is used here to represent the journey rather than the set of tools or actions.

Physiotherapist - registered health professionals who help people affected by injury, illness or disability through movement and exercise, manual therapy and education. Physiotherapists within this site provided assessment and interventions for older people who were experiencing changes in their movement, strength and mobility following an acute hospital admission.

Rehabilitation – is used to describe a set of interventions designed to optimise functioning and reduce the impact of illness or disability. It differs from other sets of interventions which have other aims, such as curative or preventative interventions. A full exploration and conceptualisation of the term rehabilitation will begin in the literature review and will permeate the full thesis.

Rehabilitation Potential – an individual’s capability to benefit from rehabilitative interventions. This is often a judgement or estimate made by health professionals. Again, a full exploration of this term will be a central focus of the thesis, beginning with an illustration of current knowledge and issues within the literature review.

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Firstly, I would like to thank the ward community who were at the centre of this research study. Particular thanks are extended to the patients and families who gave their consent for their own care to become the focus of observations. And to the occupational therapists and physiotherapists who enthusiastically contributed to the study in its entirety.

Alongside those who were directly involved, thanks also go to the wider team and the clinical and service managers who created an open culture for observational research to take place.

Thanks to my supervisors, Dr Katherine Baker and Dr Cathy Bailey who have maintained unwavering belief in the project, and in me.

Finally, thank you to Jim, Mam, Kate, Sam, Molly and Anna.

Author's declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee / University Ethics Committee on 17th July 2015 and the NHS National Research Ethics Committee on 11th November 2015.

I declare that the Word Count of this Thesis 82,462

Name: Gemma Bradley

Signature:

Date: 30th August 2018

CHAPTER ONE: INTRODUCTION TO THE THESIS

The focus of this study is to explore the reasoning and decision-making of health professionals related to the assessment of rehabilitation potential of older people and the recommendation of subsequent rehabilitation pathways. This was initially motivated by both clinical and academic interests; by my desire to understand a reasoning process I had myself engaged in as a clinical occupational therapist; alongside an educational desire to prepare future health professionals. I was further inspired by an awareness of the imperative need for knowledge generation and critical thinking in relation to care and services for older people with complex health needs.

1.1 My position – influences on the early development of the study

The concept of reflexivity recognises that the orientations of the researcher are shaped by their own values, interests and socio-cultural histories and that this biography will permeate throughout enquiry of a qualitative nature (Hammersley & Atkinson, 2007). Making these constructs explicit is an essential part of the research process and this therefore, is the first of several sections which attempts to recognise the orientations of the researcher – at this early point, to recognise the lens through which the research was originally conceptualised.

I am a qualified occupational therapist. I practiced clinically within the NHS, mainly in roles providing services for people following stroke (in inpatient acute and rehabilitation services, alongside a community stroke team), before moving to my current role as a senior lecturer in occupational therapy where I have been for 11 years. My main responsibility in my current role is the delivery of education for pre-registration occupational therapy students, although I do contribute to teaching students from wider health professional programmes.

I am also female, aged in my late thirties, and of White British origin. Although it was difficult to find more recent demographical information, statistics published in 2006 (Yar, Dix & Bajekal) report that at that time, women accounted for 80% of the healthcare workforce and were the largest gender in all groups except for medicine and dentistry; 68% of the workforce were aged between 35 and the state pension age; and 90% of the workforce were white. Whilst there may have been some changes in the past decade, it is hard to imagine dramatic shifts in these dominant groups. Therefore the fact that I ‘fit’ with the norms of a healthcare role is important to note and may have helped with acceptance and research positions in this setting.

My original interest in decision-making and rehabilitation potential grew out of my personal experience as a clinical occupational therapist. I would frequently be asked questions about a person’s rehabilitation potential, often for patients following a stroke, and often at an early point in their care and pathway. I would also often finding myself asking other professionals about the rehabilitation potential of a patient, or writing the expression in clinical records, often recording statements such as ‘limited rehabilitation potential’.

There were many issues which challenged me. I had often only known a patient for a short time before I was asked for this professional opinion. I frequently wondered whether my evaluation was similar to that of other clinicians. And I was acutely aware of some of the high stakes decisions which surrounded this often passing discussion or note in a clinical record, such as whether someone would be moved to a rehabilitation bed, referred for community interventions or perhaps quickly referred to a 24-hour care environment if the evaluation had been unfavourable. Transparency about my personal experience highlights that I was approaching this enquiry with professional knowledge as an occupational therapist and with a personally held view that judgements about rehabilitation potential were linked to high stakes decisions and outcomes for patients.

I have never worked clinically within the NHS Trust or geographical area where the research took place. I do however have professional links with the occupational therapy team within this Trust – some of whom were previous students and many are practice educators for pre-registration students. I had a number of ‘chance’ conversations with occupational therapists from this Trust who expressed anecdotally that they were also interested in this topic and that they thought their Trust had an openness to research of this nature. I then utilised a professional contact with the occupational therapy service manager to begin to develop a partnership for the purpose of the research. Whilst constructing this partnership, I was grateful of existing relationships to help to open doors and to promote feelings of professional comfort (perhaps with some early awareness of some of the uncomfortable issues ethnographic research may provoke), but also keen to not face challenges of over-familiarity or blurring of boundaries that returning to a previous place of work may create.

Finally, in my educational role, I am regularly exposed to issues in occupational therapy practice through the sharing of stories from students and educators. With honesty, such stories are often focussed on issues of challenge and pressure within professional practice. Although occupational therapy spans many specialisms, client groups and sectors, because of my own clinical experience I have a familiarity of the experiences within the acute hospital setting and particularly for older people following an acute hospital admission and therefore perhaps tune in to such experiences in a different way. Through trying to facilitate realistic preparation for occupational therapy students, I have a particular interest in healthcare decision-making and the role that therapists can play in decision-making in acute care.

The position of insider or outsider will be commented upon in a later section although it is perhaps helpful to summarise that some of this history contributed to subsequent research positions. At the outset, my position could have been interpreted as an ‘insider’ within the discipline of occupational therapy and to an acute hospital system, although potentially an outsider to other disciplines and to current clinical practice in general.

1.2. Background

With an undisputed ageing population in the UK, there are well-reported pressures related to unplanned acute hospital admissions, relating to significant reduction in bed numbers alongside simultaneous increases in patients treated (The Kings Fund, 2017). Admissions for older people account for the vast majority of hospital emergency bed days, with 62% of all hospital bed days in 2014-15 occupied by people over 65, and 25% occupied by those over 85 (The National Audit Office, 2016). Bed use for this age group has also seen the greatest increases in the last ten year period (NHS Digital, 2017). Therefore, understanding pathways for this patient group is of understandable significance.

Because of reducing bed capacity and increasing demand, alongside major reconfigurations in long term hospital-based care, there has been particular emphasis on the need to understand the flow of patients through systems (The Kings Fund, 2013; 2017). The Kings Fund acknowledge that efforts to make effective use of bed capacity should focus on the relatively small numbers of older people who often stay in hospital for a long time (2017). The use of non-emergency and community services to reduce demand on the emergency system in a timely and efficient way is also receiving important attention.

Older age is associated with an increased likelihood of living with multiple chronic conditions and a growing number of functional and cognitive impairments (The Kings Fund, 2012), with studies suggesting that about half of the population aged over 75 will live with three or more chronic conditions (Anderson, 2011). Older people are therefore likely to be admitted to acute hospitals for wide-ranging and often co-existing medical, surgical, psychological and social needs, not easily remedied by one, disease-specific treatment or pathway.

For emergency admissions, average length of stay in hospital for people over 65 is 11.9 days, in comparison to a population average of under 5 days (The National Audit Office, 2016; NHS Digital, 2017) and decisions about readiness and appropriateness of transfer of care to services who can meet ongoing needs are often complex. Evidence does however suggest that the way in which hospitals are organised can influence admissions, length of stay and readmissions, such as the availability of senior physicians (White, Armstrong & Thakore, 2010), dedicated assessment wards (Cooke, Higgins & Kidd, 2003), timeliness of therapist assessments (Jasinarachchi et al, 2009) and patient and carer involvement in decision-making (Henderson et al, 2011).

Evidence suggests that up to 35% of older people experience a deterioration in ability to undertake activities of daily living between baseline and hospital discharge, with 12% of these people experiencing this reduction between the time of admission and the point of discharge (Covinsky et al, 2003). Older people can often have extreme responses to even the most straightforward reasons for hospital admissions, are at risk of functional decline during and after hospital admissions, and often require a longer recovery phase of care (NHS National Institute for Health Research, 2017). A rehabilitative phase of care therefore plays a pivotal role in helping people to live and recover well, whether this be in hospital, in people's homes or in other care environments.

The recognition of the pivotal role that rehabilitation plays in maintaining quality of life and reducing dependency in older age, alongside reducing pressure on acute services and cost-containment across health and social care, means maximising the use of these services is of central concern (Ward et al, 2008). However, in a climate of reduced beds and increasing demand, it is the complex reasoning informing the allocation of finite rehabilitation resources which is central to this project. Burton et al (2015) suggests that it is a reality that ‘healthcare professionals will have to continue to allocate resources in ways that balance political, ethical and service perspectives around their perception of a patient’s ***rehabilitation potential***’ (p1956).

1.3. Overview of policy and legislation

In 1997, the Audit Commission highlighted that investment in preventative and rehabilitative services was not adequate and that this was contributing to excessive unplanned hospital admissions and also to premature transfers to long term care. A report three years later (Department of Health (DH), 2000) suggested similar trends, and suggested that approximately one fifth of bed days were being inappropriately used simply because of a lack of alternatives or availability of supporting services.

Following this, the National Service Framework for Older People (NSFOP; Department of Health, 2001) was a key policy document in promoting rehabilitation services for older people and recognised the significance in particular of a range of services developed under the umbrella of ‘Intermediate Care’. Intermediate Care was proposed as a new layer between primary and secondary health care services to help prevent unnecessary hospital admissions, promote timely and, if possible, early discharge, and reduce or delay the need for long term institutional care (Department of Health, 2001). The NSFOP also encouraged a range of providers (including health, local authority and independent providers) to develop integrated ways of working and contributed to the emergence of many models of service delivery. Recent National Institute for Health and Care Excellence (NICE) guidelines on ‘Intermediate Care including Reablement’ were published in 2017, which continued to place emphasis on the importance of services to deliver rehabilitation and support following hospital admissions, alongside proactively preventing unnecessary admissions to both hospital and 24-hour care environments.

Since the first publication in 2010, the annual NHS Outcomes Framework is the way by which the government monitors key health outcomes and how the NHS is performing (NHS Digital, 2018). More recently, it has also introduced similar Outcomes Frameworks for Social Care and Public Health. The 2018 NHS Outcomes framework places continued emphasis on helping older people to recover and live well following hospital admissions through measuring the proportion offered rehabilitation following acute admissions and measuring the proportion still at home following provision of reablement and rehabilitation services (NHS Digital, 2018). The similar Outcomes Framework for Adult Social Care also places importance on measuring the extent to which the need for long term care is reduced through the provision of reablement, and monitoring delays in transfer from hospital which are attributable to adult social care (Department of Health and Social Care, 2018). Whilst introduced with the aim of moving away from performance targets to establishing priorities and measuring national outcomes, the Outcomes Framework continues to require reporting of a wide range of data at a local, organisational level, such as adverse events, length of stay and mortality rates.

Consideration of how services are paid for is the focus of ongoing and significant attention, largely attributable to the passing of The Health and Social Care Act (Department of Health, 2012). However, the issues are far from new and can be traced back to the origins of Payment by Results (NHS Plan; DH, 2000) and the move to Foundation Trust status leading to scrutiny of financial viability. The Health and Social Care Act provided a comprehensive legislative framework to commence far-reaching reforms across the NHS. It outlined the evolution of a framework for restructuring how services are commissioned and paid for, and introduced Clinical Commissioning Groups (CCGs) to determine local health needs and to commission services and manage budgets accordingly. Included within this modernisation was the ongoing development of national tariffs attached to particular services and episodes of health care. Although much of this is still emerging, the Act created an environment where tariffs for episodes of rehabilitation and new providers of rehabilitation services could emerge. As older people are the largest users of NHS services, impact on services delivered for older people is inevitable.

The needs of older people with multi-morbidity are increasingly being recognised in contemporary policy and professional guidance. The condition of 'frailty' is now a frequently cited condition of modern ageing, defined as a condition which 'develops as a consequence of age-related decline in multiple body systems, [resulting] in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or fall' (NHS England, 2014). Over recent years, many guidance documents have been published highlighting the specialist needs of those living with frailty and including recommendations on managing needs in primary, secondary and social care (NHS England, 2014a; NHS National Institute for Health Research, 2017). Notably, the routine identification of frailty is now part of the General Practice Contract for 2017/18 (NHS England, 2018), recognising that assessing and discussing frailty, and the associated risks for the person, are most effective before reaching advanced stages and before people are acutely unwell.

NICE guidance on clinical assessment and management of multi-morbidity (2016a) also recognise the complex needs of people who live with multi-morbidity and provides recommendations for management in primary care, alongside comprehensive, integrated, assessments during hospital admissions. This guidance also emphasises the importance of establishing priorities and goals to commence integrated planning before multi-morbidity reaches advanced stages of frailty.

The Care Act (Department of Health, 2014) outlined reforms to the provision of social care for adults and older people. The Act places responsibility on local authorities to arrange service provision which assists to prevent or delay the need for care and support and to ensure social care and health services are integrated to promote health and wellbeing and to reduce or delay the need for services. It also highlights the role of local authorities in helping people regain skills, for example after a hospital admission. Considering rehabilitation as a strategy to facilitate improvement, prevent decline and reduce dependency, this places joint responsibility for rehabilitation between health and social care and emphasises the importance of integrated models of service delivery.

Service user involvement in decisions about their care is a professional requirement (Health and Care Professions Council (HCPC), 2013) and is emphasised within current national policy drivers (DH, 2010). More specifically, shared decision making is advocated by the National Institute of Health and Care Excellence, emphasising that users of adult NHS services should be actively involved, with the support of health professionals to make fully informed choices about their treatment and care (NICE, 2012).

To summarise, current policy and strategic drivers recognise the importance of services and pathways for frail older people, including rehabilitation services which play an integral part in maintaining quality of life and reducing dependence on care services. However, the policy context also illustrates the complexity of service provision with multiple funding streams, providers and models of service delivery. How practitioners are navigating the complexity which exists at this macro level, in order to make decisions about which individual patients might benefit from different rehabilitation services at a local level is a motivator for this study. The background of financial scrutiny and changes to tariffs and commissioning adds additional layers to this area of enquiry.

1.4 Research Aim and Objectives

Developed at an early stage of this research for the purposes of the proposal and the necessary approvals, and refined through engagement with literature, policy and key stakeholders in the field, the research aims and objectives are outlined below:

1.4.1. Research aim

To explore health professional’s reasoning and decision-making related to the assessment of rehabilitation potential of older people in hospital and recommendation of subsequent pathways.

1.4.2. Research objectives

- To explore the meaning of the concepts of ‘rehabilitation’ and ‘rehabilitation potential’ to occupational therapists, physiotherapists and patients

- To map the reasoning process of health professionals involved in evaluating rehabilitation potential and when making decisions about rehabilitation pathways for older people

- To compare the occupational therapy and physiotherapy role in evaluations of rehabilitation potential and decisions about rehabilitation pathways

- To describe influences on decisions regarding rehabilitation potential and subsequent pathways

- To explore how patients and families are involved in evaluations of rehabilitation potential and subsequent recommendations regarding treatment and care.

1.4. Outline of subsequent chapters

Chapter Two presents an overview of literature in relation to the main conceptual elements of the study – namely rehabilitation, rehabilitation potential and decision-making – all framed within the context of unplanned and rehabilitation pathways for older people. This chapter illuminates existing knowledge and current gaps.

Chapter Three introduces the methodological approach taken, including a presentation of the theoretical underpinnings, justification for the approaches and any alternative positions considered. This position is then utilised to explain, in detail, the methods used to gather and analyse data, to ensure ethical research practice and to communicate the consideration of research rigour and quality.

Chapter Four is the first of four chapters to present the research findings. This first chapter, entitled 'Descriptions', presents a thick descriptive account of the research environment and the roles, systems and practices which surround health professional decision-making. The chapter concludes with a descriptive account of the decision-making process to evaluate rehabilitation potential and reach decisions about rehabilitation pathways.

Chapter Five is the second research findings chapter and is entitled 'Social Construction and Meaning-Making of Rehabilitation and Rehabilitation Potential'. It presents the meanings of concepts which are central to the research study and how these concepts were socially constructed within the setting.

Chapter Six is entitled ‘The Ethical Dimensions of Rehabilitation Potential’. This chapter discusses the ethical nature of rehabilitation decision-making which emerged as significant within the analysis of findings.

Chapter Seven is entitled ‘Professional Roles’ and this chapter concludes the presentation of research findings. In line with the research objectives, the professional roles of occupational therapists and physiotherapists are specifically examined within the final section, with data utilised to explore similarities, differences and issues pertinent to these roles. Within chapters four-seven, participant quotes, extracts from records and observations from fieldnotes are given the important emphasis that they richly deserve.

Chapter Eight presents a critical and interpretive discussion of the findings in light of wider literature, policy and theoretical frameworks. It illuminates the ways in which meanings of rehabilitation concepts are shaped by professionals, patients and wider society; offers explanatory insights into how people are acting towards such meanings and; how this is subsequently shaping contemporary health services and professional practice.

Chapter Nine concludes this research study. It firstly revisits the findings in line with the revised aims and objectives and uses this to illustrate the unique contribution to knowledge. This section goes on to discuss implications for practice – including those that could be directly influenced by professionals, alongside wider implications for health policy, strategy and research. The chapter also recognises strengths and limitations with the current study and provides recommendations for future research.

1.5. Writing Conventions

All data has been edited throughout to remove idiosyncratic details and preserve anonymity. In relation to health professional participants, they are simply identified by their role (e.g. one physiotherapist expressed that…) or by an interview participant number (e.g. I1). Where idiosyncratic details, such as gender or grade, had the potential to identify individuals, this information has been omitted. This was important in the context of such a localised setting with a small number of participants.

The term ‘patient’ is used throughout to represent a person receiving care and services. Critical consideration was given to other terms such as service-user, client and customer, all of which are perhaps reflective of a more contemporary and active position for this group in today’s health and care services. However, the word patient was an accepted part of language and discourse within the research environment and therefore the use of this term within this written account was a deliberate choice.

Finally, and as identified within the glossary, the term ‘health professional’ is used interchangeably with ‘practitioner’ to refer to employed members of the healthcare team including nurses, doctors, therapists and social workers. Where it has been important to attribute extracts or perspectives to particular professional roles, this has been clearly identified. In other places, the term health professional or practitioner may have been used to reflect issues affecting groups as a whole, or to maintain anonymity if this was an area of concern. I have avoided abbreviating the names of health professional roles in line with current writing conventions (such as ‘OT’ and ‘PT’), except to indicate exact terms used by participants (for example the terms used in verbatim quotes and clinical records) or in places where this has assisted with clearer formatting (such as tables or appendices).

CHAPTER TWO – LITERATURE REVIEW

2.1. Chapter introduction

This literature review presents current knowledge and understanding relating to three overarching concepts underpinning this research: rehabilitation; rehabilitation potential; and rehabilitation decision-making; all discussed in the context of older people.

Searches were undertaken using Northumbria University Library Search, Cinahl, Medline and Google Scholar using the search terms outlined in Table 1. Hand searches were also undertaken and relevant literature was utilised to further understand definitions and policy context. In relation to ‘rehabilitation potential’, there was a paucity of evidence particularly pertaining to older people and therefore the search was broadened to examine the concept in relation to wider fields.

Table 1: Literature search strategy and search terms

<table>
<tr><td>Rehabilitation (rehab*; reablement)</td><td colspan="3">AND</td><td>Older (old*, older people, elderly, frailty, geriatric*)</td></tr>
<tr><td>Rehabilitation potential (rehab* potential; potential)</td><td colspan="3">AND</td><td>Older (old*, older people, elderly, frailty, geriatric*)</td></tr>
<tr><td colspan="5">Rehabilitation potential (rehab* potential; rehabilitation AND potential)</td></tr>
<tr><td>Decision making (decision-making; decision; evaluation; judgement; reasoning)</td><td>AND</td><td>Rehabilitation (Rehab*; reablement)
OR
Rehabilitation potential (rehab* potential; potential)</td><td>AND</td><td>Older (old*, older people, elderly, frailty, geriatric*)</td></tr>
</table>

2.2. Rehabilitation for older people

2.2.1. Defining rehabilitation

Defining and describing rehabilitation is a complex challenge, and indeed the term rehabilitation, when considered alongside specialisms such as stroke, spinal injury, hip fracture or heart failure, results in the emergence of many different descriptions and meanings. The term can also be paired with terms such as vocational rehabilitation, cardiac rehabilitation, sports rehabilitation and offender rehabilitation, amongst others, and again, even wider variances in descriptions and models add to the complexity of the concept.

The World Health Organisation (WHO), in their recent publication entitled ‘Rehabilitation in Health Systems’ (2017) define rehabilitation as ‘a set of interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment’ (p11). This document goes on to outline that the purpose of rehabilitation is to maximise people’s ability to live, work and learn to their optimum potential, and that functional difficulties associated with ageing can also be reduced through rehabilitation.

The 2017 WHO definition is broadly similar to the earlier WHO definition of rehabilitation integrated within the influential International Classification of Functioning, Disability and Health publication (ICF; WHO, 2001). This framework defined rehabilitation as ‘a health strategy that aims to enable people with health conditions experiencing or likely to experience disability to achieve optimal functioning in interaction with the environment’ and importantly to this project, was a definition adopted by physical rehabilitation medicine (Stucki, Cieza & Melvin, 2007). The ICF also provides insight in to the purpose and focus of rehabilitation; with a focus not on cause but on impact of impairment, and the need to address elements at the level of impairment and dysfunction, but also at the level of accessibility of activities, environments and societies.

Other definitions focus more on a rehabilitation process with core components. Wade (2005) defines rehabilitation as an “educational, problem-solving process that focuses on activity limitations and aims to optimise patient social participation and well-being, and so reduce stress on carer/family” (p814). An alternative definition proposes rehabilitation as a “goal-orientated and time-limited process aimed at enabling an impaired person to reach an optimal mental, physical and/or social functional level thus providing him or her with the tools to change his or her own life” (United Nations, 2009). Hammell (2006) defines rehabilitation as “a process of enabling someone to live well with an impairment in the context of his or her environment, and as such, requires a complex, individually tailored approach” (p127).

With definitions of rehabilitation presenting broad-brush statements, it is perhaps the elements which go in to rehabilitation which give the concept meaning. Authors have recognised this, suggesting that recognising the ‘active ingredients’ of rehabilitation may make it easier to understand or research (Whyte, 2009). Examples within literature also make reference to a ‘black box’ of rehabilitative interventions, suggestive of difficulties characterising what it actually is (DeJong et al, 2004; Whyte & Hart, 2003). Some attempts aim to summarise the different activities such as activities to promote musculoskeletal, cardiopulmonary, or cognitive and perceptual improvements (DeJong et al, 2004). Other examples focus more on the delivery of rehabilitation, highlighting the centrality of patient goals, a multi-professional approach, the allocation of resources to hospital and community models, and collaboration with patients and family (Wade, 2015; Wade 2005; Whyte, 2009; WHO, 2017).

To add complexity to the many contexts and specialisms, the term rehabilitation is also used to describe an underpinning approach or theoretical basis, based on beliefs and models of health, illness and disability, alongside theories of behaviour change (Wade, 2005). From a public and population health perspective, it is a term used to describe a health strategy with prevention, cure and support cited as other inter-related health strategies (Stucki, Cieza & Melvin, 2007). Rehabilitation research further hinders the quest for clarity with recognition that research evaluating and exploring rehabilitation themes does not always specify the activities involved and often it includes large numbers of multi-faceted interventions grouped together ambiguously (Wade, 2005).

2.2.2. Models of rehabilitation for older people

Models of specialist rehabilitation, for treatment of conditions such as stroke, hip fracture and pulmonary and cardio-vascular diseases are well accepted and established. However, it is recognised that for older people with specialist needs associated with ageing, models of care and service provision, alongside the impacts and effectiveness of rehabilitation, are less clear (Bachmann et al, 2010). Despite this, demand for rehabilitation for older people is significant, linked to demographic patterns, changes over time in orientation of acute healthcare services, and a growing evidence base that rehabilitation is an integral component of restoring health and wellbeing after periods of illness or injury.

Rehabilitation service delivery models include the use of inpatient beds in rehabilitation wards and units; rehabilitation provided in identified residential step-down units or within residential and nursing homes; community rehabilitation in the person’s home; and, more recently, examples of tele-rehabilitation which could involve interventions provided through information and communication technologies. Also, the provision of rehabilitation is not just limited to wards or services identifying themselves as providers of rehabilitation, and is more realistically being delivered for older people across general wards and teams and by many and varied providers of health and social care services. These models also have diverse funding and commissioning arrangements and can be delivered by NHS, Adult Social Care and private providers.

The NSFOP (Department of Health, 2001) received criticism for a lack of detail and reference to an evidence base relating to effective models of service delivery, and in particular, a lack of clarity about the term ‘Intermediate Care’ (Melis et al, 2004). In the 15 years since the implementation of the NSFOP, there have been many exemplars outlining how services have been developed and evaluated (Young et al, 2007; Cunliffe et al, 2004; Griffiths et al, 2007) although this has also resulted in challenges to practitioner decision-making about which services may best meet individual needs, and challenges to commissioners and policy makers to understand the landscape and evaluate which services offer clinical and cost effectiveness.

Furthermore, it could be argued that more recent policy and legislative developments have only continued to foster diversity in services through the encouragement of new providers (for example private companies and charities) and through the joint responsibility placed on Health and Social Care. The latest guidance on Intermediate Care from the National Institute of Health and Care Excellence (NICE, 2017), continues to recognise different types of intermediate care, although reinforces four broad categories including crisis-response, home-based, bed-based and reablement. Bed-based intermediate care and reablement services are of particular note to this study (with descriptions of the services experienced during fieldwork provided in Chapter four).

Reablement has been defined as ‘assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. [It is] delivered by a multidisciplinary team but most commonly by social care practitioners’ (NICE, 2017; pg 15). Parker (2014) recognises that there are multiple challenges in understanding the differences between terminology such as reablement, rehabilitation and intermediate care although the time limitations, the difference between health and social care provision and the focus on adjustment rather than regaining skills represent some ways that services are differentiating at a local level. It is interesting to note that difference and overlaps are not clearly explained in recent NICE guidance (2017) perhaps representing a missed opportunity to develop clarity on this important issue.

The prevalence of cognitive impairment increases with age (Ray & Davidson, 2014) and is therefore of importance to a study which focuses on older people. In particular, recent estimates suggest that one or more of dementia, delirium or a non-diagnosed cognitive impairment as indicated by medical screening was present in almost 40% of all patients aged over 65 admitted to a general hospital, and rises to over 50% in those aged over 85 (Reynish et al, 2017). Estimates have also suggested that approximately 60% of people receiving care services in their own homes are living with cognitive impairment, and this figure is almost 70% of those living in residential care (United Kingdom Homecare Association, 2015; Prince et al, 2014).

Although the term cognitive rehabilitation is a recognised term used to describe non-pharmacological methods focussing on identifying and addressing needs and goals for those with cognitive impairment (Bahar-Fuchs, Clare & Woods, 2013), synthesising messages and implications from available evidence is complex. Definitional challenges exist with terms such as cognitive training and cognitive interventions often used interchangeably within literature discussing rehabilitation focussed on remediating the effects of, or adjusting to, cognitive impairment (Bahar-Fuchs, Clare & Woods, 2013). Once again, many examples also discuss cognitive rehabilitation in relation to specific pathways such as stroke and acquired brain injury (das Nair et al, 2016; Kumar et al, 2017). In a recent Cochrane systematic review of enhanced models of rehabilitation for those with cognitive impairment following hip fracture, only five studies were included, the studies were small and were deemed to be of low quality and none assessed the primary outcome of the influence of the model of rehabilitation on cognitive function, instead exploring the impact of the cognitive impairment on the improvement of physical function (Smith et al, 2015).

To summarise, integrated models of rehabilitation which support older people to recover from and adjust to periods of ill-health, new onset of health conditions, or trajectories of ageing and frailty which may result in wide-ranging cognitive and physical impairments are not clearly described or supported within literature, although are supported in policy (NICE, 2017). The picture becomes particularly blurred when considering that, within research, measures of cognitive impairment are highly contestable and there are many examples where people with cognitive impairment or excluded from studies (Crocker et al, 2013). Furthermore, studies which specifically address or explore models of rehabilitation for those with cognitive impairment report outcomes often relating to physical improvements. Issues of particular relevance to this study, such as the link between cognitive function, rehabilitation potential and rehabilitation outcomes are integrated within other sections.

2.2.3. Effectiveness of rehabilitation services for older people

As outlined in the previous section, there are many different ways in which rehabilitation can be provided for older people. Even with the acknowledgement that some models of rehabilitation for older people are condition-specific and will therefore contribute to the variation (for example stroke rehabilitation, pulmonary rehabilitation and cardiac rehabilitation among others), there are still geographical differences in the availability of slower-stream rehabilitation beds, the availability and organisation of intermediate care facilities, and the capacity of community rehabilitation or outpatient provision (The Kings Fund, 2012). Although, in line with an agenda to commission services based on the needs of local populations (The Health and Social Care Act, 2012), the variation provides a challenge to practitioners, commissioners and policy-makers to understand efficacy.

In line with many condition-specific delivery models, much of the research attempting to evaluate effectiveness of rehabilitation is condition-specific – for example the systematic reviews from the Cochrane Collaboration evaluating home-based rehabilitation in comparison to centre-based rehabilitation for cardiac conditions (Anderson et al, 2017), and assessing the effectiveness of models of rehabilitation following joint replacement (Khan et al, 2008). Research also reflects the fact that this in an international topic of interest although models of service delivery (mainly linked to how services are funded) are significantly different. However, there is general consensus that periods of organised, multi-professional rehabilitation are effective in promoting health and wellbeing benefits such as positive functional outcomes and reducing dependency on carers.

There are some examples of studies attempting to synthesise results from published research particularly relating to the provision of rehabilitation for older people. The Cochrane Collaboration attempted to compare rehabilitation for older people provided in care homes, hospitals and own home environments (Ward et al, 2008). The review of international published research suggested that there was insufficient evidence to compare the effects of rehabilitation in care home environments, hospital environments and own home environments although this was mainly linked to a lack of clarity in descriptions and specifications of rehabilitation and the weaknesses in existing research, rather than an ability to establish no effect.

The Cochrane Collaboration also led a review aiming to determine whether nursing-led inpatient intermediate care units are effective in preparing patients for discharge in comparison to usual inpatient care (Griffiths et al, 2007). There was some evidence that patients who received care within the nursing-led unit were better prepared for discharge although this could have been related to a near significant increase in the average length of stay for these patients. Also, although there were no statistically significant adverse events between the groups, the review did suggest that they could not rule out an increase in early mortality in relation to nursing-led intermediate care. A further Cochrane Review comparing day hospital care for older people versus alternative forms of care (Brown et al, 2015) concluded that there is low quality evidence that medical day hospitals appear effective when compared with no care, although there is no clear advantage over other medical care provision.

A large systematic review and meta-analysis of randomised controlled trials (RCTs), including 17 trials with a total of 4780 participants, evaluated the effectiveness of inpatient rehabilitation specifically designed for geriatric patients in comparison to usual care (Bachmann et al, 2010). In order to meet inclusion criteria for this systematic review, the rehabilitation provided needed to be multidisciplinary in nature (with a minimum of a geriatrician and a nurse) alongside including active physiotherapy, occupational therapy or both, and meet the principles of the ICF Rehabilitation Framework (Stucki, Cieza and Melvin, 2007). The authors noted issues related to methodological quality with many of the studies, for example only 10 of the 17 included studies reported adequate concealment of allocation and only seven studies blinded the independent outcome assessors. Despite this, the authors concluded that a period of specialised geriatric rehabilitation showed beneficial effects over usual care in that it was more likely to result in improved functional outcomes and less likely to result in a nursing home admission or in death either during the admission or at follow up.

However, when looking beyond the headlines of positive generalised benefits, there were only two areas where statistical significance was demonstrated; inpatient orthopaedic rehabilitation demonstrated significant improvements in functional outcomes in comparison to usual care; and studies with a lower mean age demonstrated statistically significant reduction in admissions to nursing homes than those with a higher mean age. Both of these statistically significant findings are perhaps unsurprising. Furthermore, nine of the 17 studies related to specialist orthopaedic geriatric rehabilitation, with eight relating to the more heterogeneous geriatric rehabilitation which forms the basis of this study. With only four of the original studies carried out in the United Kingdom (UK) and the research publications dating from 1984-2007, the likelihood of fast-paced change to rehabilitation services and pathways within contemporary UK healthcare systems raises further questions about currency and transferability.

Despite questions about statistical significance and transferability of findings, the scale of the review by Bachmann et al does lend credibility to some of the wider observations of the study and the authors. Firstly, although all services needed to include a geriatrician and a nurse, there was wide variance in the make-up of the rehabilitation team meaning understanding in relation to the components of effective rehabilitation for older people continues to represent a challenge. Secondly, the review only identified studies pertaining to general geriatric rehabilitation or orthopaedic geriatric rehabilitation suggesting that rehabilitation targeted at particular health conditions but specialising in the needs of older people is either not being provided, or perhaps more realistically, not being researched.

Studies have also attempted to evaluate rehabilitative care for older people in community hospitals by comparing outcomes with standard care in a general hospital (Young et al, 2007). Patients who received rehabilitation in the community hospital had slightly higher independence outcomes after six months, although length of stay, mortality, discharge destination and patient satisfaction were not statistically different. A linked study which presented an economic evaluation using the same participant data, suggested there was no significant difference in cost (O’Reilly et al, 2008). The results from both studies suggest there could be small improvements in functional outcomes when rehabilitation is provided in a community hospital although many other outcomes when compared to rehabilitation provided in a general hospital were similar. It is perhaps the absence of significant differences which provide some of the key messages here with locality-based, closer-to-home care providing a meaningful alternative to acute general hospital care, with no suggested adverse effects or increased risks.

Cunliffe et al (2004) conducted a RCT including 370 patients to compare an early discharge rehabilitation team with usual care (management in hospital until fit to go home) for older people. They found that health outcomes, measured by activity limitation and psychological wellbeing were improved in the short term for those in receipt of rehabilitation from the early discharge team, with improvements also noted in carer wellbeing and no differences noted in adverse events such as readmissions or mortality rates. The authors recognised that it was potentially the organised, person-centred rehabilitation approach promoted by a team who were aware of the research trial, rather than the superiority of a home setting over a hospital setting, which could contribute to favourable results. They also recognised the resources which accompany a large RCT and that the benefits of early discharge rehabilitation may be lost if the realities of resource constraints compromise services.

2.3. Rehabilitation potential

2.3.1. Definitions of rehabilitation potential

The NSFOP (2001) recognised that ‘good management’ of an older person following a hospital admission would include attention paid to rehabilitation potential. Rehabilitation potential has been defined as an ‘estimate of the individual’s capability of cooperating with a rehabilitation programme and making measured functional gains’ (Rentz, 1991). Zhu et al (2006) define rehabilitation potential retrospectively if a person has made functional improvement or remained at home over a period of one year and discuss that an effective assessment of rehabilitation potential relates to the selection of individuals who are most likely to benefit from rehabilitation. In a study by Burton et al (2015) professionals consistently described the concept of rehabilitation potential referring to two main elements - the visible achievement of goals or outcomes over time and the observation of carry-over within and across therapy.

It has been suggested that the clinical assessment of rehabilitation potential is an everyday occurrence in hospitals (Cunningham, Horgan and O'Neill, 2000; Burton et al, 2015) yet definitions and explanations to support practitioner understanding and decision-making within literature are at times vague. Shun et al (2017) attempt to explore factors influencing perceptions of rehabilitation potential but do not clearly define how they are interpreting this foundation concept. Other studies allude to judgements about rehabilitation potential with limited explanation of what this means or entails (Kumlien et al, 1999; Kotiadis, Carpenter and Mackenzie, 2004). For example, a study by Arling, Williams and Kopp (2000) explores therapy use and discharge outcomes for elderly nursing home residents and states the exclusion of people who are deemed to have conditions which would limit rehabilitation potential but provides limited detail or examples.

Enderby et al (2017) published an expert commentary on the meaning and value of the term 'rehabilitation potential', involving professionals with expertise in stroke rehabilitation. The article raised critical insight in to the unclear nature of the concept, alongside the lack of recognised decision-making tools or algorithms. Critically, and perhaps to illustrate the ambiguity, the article does not offer a definition of the central concept.

2.3.2. The significance of rehabilitation potential

The definition above from Zhu et al (2006) relating an effective assessment of rehabilitation potential to the selection of individuals who are most likely to benefit from rehabilitation suggests a clear link between a judgement about rehabilitation potential and the allocation of rehabilitation resources. Burton et al (2015) discusses this in further detail suggesting that, at an individual level such decisions can determine when and if rehabilitation begins, the intensity of rehabilitation required and at what point rehabilitation may fail to deliver meaningful outcomes. Burton et al recognised that at an organisational level, those thought to benefit most from services can be prioritised and those with limited potential can be tracked to the most appropriate environment. They also highlighted other, more subtle, reasons why decisions about rehabilitation potential are of significance, recognising the emotional significance for those health professionals with a responsibility for making such decisions; a process which potentially involves labelling or putting people in boxes; and an awareness that decisions about potential can become self-prophesying.

2.3.3. Judgements about rehabilitation potential

Burton et al (2015) used multi-professional focus groups to discuss a hypothetical case scenario with the aim of encouraging discussion about judgements of rehabilitation potential following stroke. Participant descriptions suggest that judgements about potential tend to emerge from observing responsiveness to therapy, even through potential failure or poor outcomes, rather than from predictor variables prior to starting rehabilitation. Indeed in simple terms, this study suggests that rehabilitation needs to commence before meaningful decisions about potential can emerge.

As there are only limited examples of studies exploring health professional judgements of rehabilitation potential, yet such studies are of direct relevance to this research, it is important to attend to the limitations. Data generated through the focus groups emerged from discussion relating to a fictional scenario and the health professionals involved were from a small number of services in a geographically close area of the UK. However, these limitations add weight to researching the concept in another geographical location, using a method which explores real-time decision in context, and exploring the transferability of findings to broader clinical contexts outside of stroke services.

In a recent qualitative study in Australia, Shun et al (2017) recruited 12 occupational therapists to participate in a consensus building data collection method to identify the most important patient-related factors when considering rehabilitation potential in people following acquired brain injury. From an original long-list of 51 items, the group achieved consensus on 11 factors as essential to consider when evaluating rehabilitation potential: age, behaviour, cognitive abilities, endurance, home environment, medical status, observed improvement in acute care post-injury, physical abilities, post-injury functional status, pre-injury functional status, and patient and family expectations. However, alongside these patient-related factors, other themes emerged from focus group discussions including the organisational context (such as time and resource pressures), professional expertise, experiential knowledge, knowledge of scientific evidence and ethical considerations. Findings present as being consistent with other studies which aim to explore factors predictive of functional gains (presented in section 2.4.2), although again hypothetical cases were utilised to explore professional reasoning.

Cunningham, Horgan and O'Neill (2000) explored the clinical assessment of rehabilitation potential of older people admitted to a geriatric rehabilitation ward, by a physician, a nurse, a physiotherapist and an occupational therapist. The findings suggested that professionals were often unsure of their own judgement about rehabilitation potential and agreement between professionals was poor. Alongside differences in approaches to assessment, the authors suggest differences in the meaning of rehabilitation potential as a contributing factor to the low levels of agreement although do not go beyond raising this as an issue for professional reflection and dialogue.

Chang et al (2011) compared judgements about rehabilitation potential amongst care home residents in Taiwan and employed caregivers involved in their care (either qualified nurses or carers). The findings found significant differences between perceived rehabilitation potential rated by residents in comparison to their caregivers. Whilst recognising the cultural and contextual differences which inevitably lead to challenges in generalising findings from this study, a study which explores a person's own perception of rehabilitation potential and the potential differences in judgements in comparison to those making decisions or responsible for taking actions based on perceived potential is worthy of note. Reasons for differences in perceptions were potentially attributed to residents being too optimistic about their potential, or caregivers being too passive in their evaluation rooted in previous frustrating experiences or ideas of cost containment.

A study by Myers et al (2009) provides insight in to a simple attempt to quantify rehabilitation potential. On admission to one of 14 rehabilitation facilities in the USA, the admitting nurse was required to use the history of the presenting condition and past medical and social information to rank rehabilitation potential using a three-point scale and this was found to have a significant relationship with functional status at discharge. However, the sensitivity of a three-point scale and the lack of information to interpret how this three-point scale was administered limit the interpretation of such findings.

With so few studies actually attempting to articulate or explore descriptions or meanings of rehabilitation potential, literature which acknowledges the absence of rehabilitation potential could provide additional insight. Arling, Williams and Kopp (2000) studied therapy use and outcomes after 90 days of 1419 elderly residents admitted to nursing homes in an identified State in the United States and stated a judgement about rehabilitation potential as an element of the study inclusion criteria. Description of the sampling method acknowledged that participants were included in the study if they were free of serious mental or behavioural problems and had no diagnosis that might severely limit rehabilitation potential. Further descriptions of those excluded from this study included people with high grade pressure sores, chronic mental health problems and an explicit terminal prognosis, among others, suggesting an interpretation in this study that the presence of physical and mental health co-morbidities reduces rehabilitation potential.

Kotiadis, Carpenter and Mackenzie (2004) present an insight in to the referral and admission criteria to Intermediate Care services in a particular locality in the UK. They discuss that rehabilitation potential was stated as part of the service admission criteria, and offer general clarification of this that a person should be able to benefit from rehabilitation. The analysis reviewed the criteria against an identified number of patients using each service and interestingly they identify that this criterion was the element that the fewest number of patients met although information about how such judgements were reached is limited. This publication was not published as empirical research and therefore lacked a rigorous discussion of concepts and methods, however, the ambiguous discussion of rehabilitation potential and discussion about judgements relating to potential are reflective of wider literature. This piece also provides an insight in to the dialogue and reasoning of professionals, where the term ‘rehabilitation potential’ is being used and judgements are alluded to, without a detailed understanding or acknowledgement of the conceptual challenges.

All of these issues are perhaps best summarised by returning to Enderby et al (2017) who suggest that the concept of rehabilitation potential is ‘imprecise, inadequately defined and influenced by the non-clinical context’(p712) and compare it to a ‘guessing game’ (p709).

2.4. Rehabilitation decision-making

2.4.1. Decision-making frameworks

It is globally accepted that decision-making is a constant requirement for those involved in health service delivery, from daily frontline decisions pertaining to patient care, to strategic decisions relating to how services are organised, delivered and funded. Healthcare decision-making therefore understandably receives significant focus with explorations of how decisions are made, discussions of how decisions are best made, or variances in decision-making (particularly when thinking about novices and experts) all widely researched. Debate about how theory can be used to improve practitioner decision-making is another area of important focus (Chapman and Sonnenberg, 2000).

There are many models of professional reasoning proposing to illuminate issues pertaining to healthcare decision-making. One such model is the Integrated Patient-Centred Model of Clinical Reasoning (Higgs and Jones, 1995). This model describes reasoning as a process of reflective inquiry, involving the client, and promoting an in-depth, contextually relevant interpretation of the clinical problem. The model incorporates the application and integration of three core elements: knowledge, cognition and metacognition. To summarise the three core elements, practitioner decision-making requires: a strong, well-organised knowledge base; the cognitive skills to analyse, synthesise and evaluate information pertaining to the clinical problem; and an ability to reflectively monitor the reasoning process and subsequent actions taken (Higgs and Jones, 1995).

In a later representation of the same model, Higgs and Jones offered further development to recognise an additional three influences: mutual decision-making, contextual interaction and task impact (2000). The inclusion of mutual decision-making was an acknowledgement of the growing move away from dependent patients to active and informed consumers of healthcare, a concept which has only continued to grow in significance and is explored within section 2.4.6. Contextual interaction refers to the interaction between the professionals, the situation and the environment and again reflects changes in physical environments and locations of healthcare but also of wider economic and socio-cultural factors impacting on decision-making. Finally, the task impact is included as an influence on reasoning to recognise that the nature of the clinical problem can be changeable, uncertain and multidimensional (Higgs and Jones, 2000).

Predictive reasoning is a term used to describe the process of envisioning future scenarios, including the exploration of choices and the implications of those choices (Jensen et al, 1999). More specifically to rehabilitation professionals, it has been described as envisioning future scenarios based on estimated responses to therapy and linked to judgements about the potential benefit an individual may gain from rehabilitation (Edwards et al, 2004; McGlinchey and Davenport, 2015). It is a reasoning type that is recognised within literature pertaining to nursing, occupational therapy and physiotherapy (Fonteyn and Fisher, 1995; Edwards et al, 2004; Hagedorn, 1996) and can be clearly linked to attempts to evaluate rehabilitation potential. The information potentially used to predict functional outcomes following engagement in rehabilitation will be explored later in this review.

Ethical reasoning involves the reasoning process used to attempt to resolve ethical dilemmas and to balance one or more values against another in an effort to act in the best interests of service users (Chapparo and Ranka, 2008). Ethical reasoning in health and care has received much attention in literature and research (Duncan, 2010; Seedhouse, 2017) and more specifically in relation to rehabilitation decision-making and hospital discharge planning (Bushby et al, 2015; Durocher & Gibson, 2010; Levack, 2009).

Set within a landscape of many and varied ethical philosophies and principles, two particular branches of ethical theory – deontology and utilitarianism - emerge as particularly relevant to healthcare and rehabilitation (Hugman, 2005; Barnitt, Wareby & Rawlins, 1998; Levack, 2009). Deontology is based on the assumption that ethical laws are duties and should be applied equally and universally to everyone in the same type of situation as a result of rules, and in the case of health professionals, codes of conduct, being applied (Hugman, 2005). Some have suggested that at the level of individual professional and patient interactions, deontological principles should be dominant (Garbutt & Davies, 2011).

In contrast, utilitarianism is founded on rational judgements about the consequences of actions with an aim to produce the greatest benefit for the greatest number (Hugman, 2005). It is suggested that wider healthcare systems have for a long time inevitably been driven by utilitarian forces, aiming to maximise finite resources for the greatest good, with the guidance provided by the National Institute of Health and Care Excellence providing examples to serve this very purpose (NICE, 2013). To summarise the difference, deontological ethics is driven by intention to do good, whereas utilitarian ethics supports the evaluation of likely consequences as the basis for action.

Seedhouse (2005) suggests that in relation to healthcare decision-making, there is often more than a technical and scientific process of reasoning and that health professionals will inevitably be influenced by values when reaching decisions. In fact, he suggests values often precede an examination of evidence and dominate decision-making behaviour in humans. Decisions which focus on who will benefit from access to rehabilitation services, and potentially considering who will benefit *more* from such services if there are competing demands, could inevitably be driven by practitioner values.

2.4.2. Decision-making – predicting who will benefit from rehabilitation

Retrospective studies in to clinical factors which predict the likelihood of functional gains are of obvious interest. Many studies have investigated factors which may predict functional outcomes for older patients including cognitive ability (Hershkovitz and Brill, 2007; Hershkovitz et al 2010; Poynter et al, 2011), increasing age (Traballesi et al, 1998), and presence of co-morbidities (Semel 2010; Press et al, 2007). There are recurrent themes within the vast literature although findings are difficult to generalise. Many studies are specific to particular patient pathways, such as hip fracture, stroke and amputation and generalising findings to an older population who may present with a number of co-existing conditions is challenging. In fact, one study which investigated predictive factors for an older population with diverse reasons for acute hospital admission identified that the main presenting condition itself did not provide an effective indication of functional gains, discharge destination or survival (Elphick et al, 2007).

Although there is general agreement about factors such as advancing age (Traballesi et al, 1998) and the severity of cognitive impairment (Hershkovitz et al, 2010) being negatively correlated to measures of functional outcome after a period of rehabilitation, functional gains are still reported for these client groups. A retrospective study of admissions to a general hospital in the UK (Elphick et al, 2007) found that successful inpatient rehabilitation – measured by duration of rehabilitation days, destination and level of support on discharge, hospital readmissions, and death during admission or within 120 days of discharge - of patients aged 90 and over is possible and the factors influencing this success, such as higher cognitive function and better premorbid functional ability, are similar to younger populations. They did acknowledge that the presence of co-morbidities is negatively correlated to the success of rehabilitation and that this inevitably occurs more frequently in the older elderly population. However this study supports the notion that rehabilitation potential may be affected, but not eradicated, by advancing age.

Many studies report the presence of comorbidities as being negatively correlated to good functional outcome following hospital admission although specificity about this issue within the evidence is a little less clear. A few studies do develop specificity on this theme with some detailing a particular condition such as diabetes mellitus (Semel, 2010), or offering approaches to grading severity (Press et al, 2007) although they present as being small in number in comparison to the many studies which simply identify the issue in a general way.

When considering the influence of depression on rehabilitation outcomes, there are examples of studies which report a negative impact on rehabilitation outcomes (Hershkovitz et al, 2007). However, there are also examples of studies where rehabilitation outcomes between those with and without depression do not significantly differ, with authors warning against limiting rehabilitation opportunities for those who present with low mood or increased apathy (Lenze et al, 2007).

Some studies develop the themes above to not only identify factors which are predictive of functional improvements, but factors which are predictive of eventual discharge outcome. Unsworth (2001) identified that performance on stairs, bed transfers, and eating as measured by the Functional Independence Measure (FIM) could accurately predict discharge home, to nursing care or to further rehabilitation in

74% of patients admitted to acute care for lower limb orthopaedic surgery. The same study achieved similar accuracy in predicting discharge destination of stroke patients but required wider factors such as bowel management, performance in instrumental Activities of Daily Living (ADL) alongside social factors including social situation and pre-admission housing (Unsworth, 2001).

Because of the multitude of studies which present information on this theme alongside international diversity in models of service provision, studies from the UK are of particular interest. A recent study from a large acute hospital in the UK identified that age, gender, Abbreviated Mental Test (AMT) score, walking ability outdoor and indoor, anaesthetic grading, need for pre-operative medical review and delay to surgery all had a significant effect on whether an individual returned to their previous place of residence after traumatic hip surgery (Nanjayan et al, 2014). The study proceeded to identify that where all of these factors were present in a person over the age of 80, they were one thousand times more likely to not return to their pre-admission home. The authors summarise that anaesthetic grading, need for pre-operative review and delay to surgery were often linked to the presence of co-morbidities and that this, alongside poor cognitive and physical function were the most significant predictors of a change in discharge destination.

Although predictive factors are clearly of relevance, the difference between rehabilitation outcomes and rehabilitation potential has been highlighted. Burton et al (2015) suggests rehabilitation outcome is dependent on many factors including the availability and receipt of clinically effective interventions and that the response to such interventions is difficult to differentiate from the responses of the research populations on which evidence for clinical effectiveness is based. Subsequently, generalisable information that predicts rehabilitation outcome is only likely to partially explain the rehabilitation potential of individuals, with wider influences on professional decision-making being relatively unknown.

Despite this, studies detailing predictive factors have been noted to use the terms rehabilitation potential and rehabilitation outcomes almost interchangeably. Semel et al (2010) conducted a study to explore the predictors of functional outcome after hip surgery in a large acute inpatient rehabilitation facility in the USA. The study identifies several significant patient characteristics which can give forewarning of a poorer functional outcome and then within the presentation of findings and discussion, claims about the links to lower functional outcome and lessened rehabilitation potential are used to express similar messages.

Another important issue of note is that some studies report excluding participants or patient data which may have been deemed to have a severe co-existing condition. The limited knowledge base about the types and severity of conditions alongside the potential areas of ambiguity noted above, result in challenges to services and practitioners when attempting to generalise or adopt key messages from findings.

2.4.3. Decision-Making - selection for rehabilitation

The presentation of literature in section 2.4.2 above, aiming to predict who will benefit from rehabilitation, precedes an overlapping element of decision-making to select those for rehabilitation in order to optimise the use of rehabilitation resources. Core underpinning values of the National Health Service (NHS) include the availability of services to all and that for most, these services are free at the point of need (DH, 2013). This availability of preventative and health promoting services for those who need it is also echoed in recent Social Care legislation (The Care Act: DH, 2014). However, as services are finite and demand, particularly in relation to older people, is significant and growing, judgements about access and need are fundamental to optimising the use of, and benefit from, rehabilitation services.

Working with eligibility or selection criteria is a frequent requirement for health professionals, from establishing who is an appropriate candidate for surgery, recruiting to clinical trials, to decision-making about equipment provision, to name a few examples. Criteria is often developed to help services and practitioners to make decisions about who should have access to a particular resource and is recognised as a way of attempting to allocate and ration services to maximise benefit and fairness (Wade, 2003). There are examples in literature of selection criteria to assist with judgements about referral and acceptance to a variety of rehabilitation services including stroke rehabilitation units, pulmonary rehabilitation, and cardiac rehabilitation (Hakkennes, Brock and Hill, 2011; Ilett et al, 2010; Ambrosino and Foglio, 1996).

As part of a wider systematic review, Hakkennes, Brock and Hill (2011) found six studies which detailed selection criteria for rehabilitation after stroke, with age, pre-stroke functional level, and post-stroke functional level consistently cited within selection criteria. However, directions of association were not always predictable – for example, in relation to post-stroke functional level, both patients with severe and mild impairments were less likely to be accepted than those with moderate impairment, providing tentative suggestions that selectors finely judge those who can achieve maximum benefits from rehabilitation. Hakkennes, Brock and Hill do indicate that there was consensus amongst studies that absolute criteria for selection for rehabilitation would be unfeasible, with potential to include inappropriate patients and exclude some who may ultimately benefit.

Considering the fact that research presents as being more fully developed in the field of stroke rehabilitation, the identification by Hakkennes, Brock and Hill of only six studies over more than a 40 year period is illustrative of under-developed empirical research in this area. The review also highlights the quality of included studies was generally poor leading to a call for more rigorous research.

Wider literature reports challenges with selection and eligibility criteria in healthcare including the fact that it is not always used (or documented) when it is recommended to be; that generic (and sometimes untrained) staff are required to apply criteria for access to specialist (and sometimes not fully understood) services; and the important fact that unless sensitivity, specificity and predictive value is proven, criteria potentially excludes people who may benefit from a service and includes those who are potentially inappropriate (Lynch et al, 2016; Wade, 2003).

Perhaps an emerging, but unquantifiable challenge, relates to who has responsibility for the application of criteria as responsibility can lie with the referring service or the accepting service (Lynch et al, 2016). A policy context of payment by results and national tariffs could lead to significant differences in the motivations of these referring and accepting services, with services potentially being motivated to reduce length of stay or to prioritise people who may reflect positive outcome measurement for a service. There is a suggestion that decisions about transfer of care from one service to another may sometimes simply be underpinned by a desire to ‘shift responsibility’ (Dodier & Camus, 1998).

Although professional bodies and policy makers attempt to provide guidance on eligibility and selection criteria, the fact that there is theoretically an infinite demand for a free and open service inevitably leads to those involved in the day-to-day delivery of care and services making decisions to manage this challenge. Lipsky (1980) suggests that it is the decisions and routines of individual workers and teams, influenced by various factors and pressures, which effectively become the public policies which assist to manage workload and demand.

The decision-making process and factors influencing decision-making has also been explored in relation to the selection for rehabilitation after stroke. Putman et al (2007) explored clinical and non-clinical factors involved in decision-making concerning admission to six European stroke rehabilitation units. Data was gathered through analysis of assessments and outcome measures relating to patients admitted to the identified units, alongside questionnaires and interviews with medical consultants. Findings revealed that factors influencing decisions could be grouped in to factors related to the patient, factors related to the network between facilities, and factors related to the referring hospital, and inconclusively, but perhaps predictably, the most influential factors differed across sites and countries.

Again in the field of stroke, Ilett et al (2010) explored the process of selecting patients for stroke rehabilitation across seven acute sites in a specific region in Australia. They found variations in practices between different acute hospitals, and suggested that acute sites may be influenced by organisational factors such as numbers of beds, availability of outpatient resources and financial incentives related to shortening length of stay. A small study by Kennedy et al (2012) revealed that rehabilitation physicians were influenced by a range of individual factors such as prognosis, age and social support, alongside organisational factors such as availability of specialist services and staffing issues when reaching decisions about selection for rehabilitation following acute stroke. The same study also attempted to investigate levels of agreement between rehabilitation physicians regarding the assessment of rehabilitation potential based on a sample of case vignettes. They found high levels of agreement for some scenarios alongside divergence for others and suggested variability is likely in this area of practice.

Hakkennes et al (2013) aimed to identify factors that assessors considered important in decision-making regarding suitability for inpatient rehabilitation after severe acute stroke in Victoria, Australia. A questionnaire was developed from a comprehensive review of the literature, and included 17 factors in total, spanning prognostic indicators, alongside social and organisational factors. The questionnaire utilised a 10-point visual analogue scale to rate the importance of each factor (from 0 – not important at all to 10

– very important) and indicate if the factor was positive (increased the likelihood of selection for rehabilitation) or negative (decreased the likelihood of selection for rehabilitation). Results highlight that, for those accepted to rehabilitation, items linked to pre-morbid status (such as pre-morbid cognition, mobility and communication), were the most influential factors but conversely, for those not accepted, factors linked to post-stroke status (current mobility, cognition and social support) were most important. Interestingly, social factors, such as level of social support and carer advocacy for rehabilitation, did not emerge as among the most important factors across the study, although were highlighted as influential in some scenarios. Additionally, organisational factors were not highlighted as significant in either those accepted or not accepted for rehabilitation. The use of an unvalidated visual analogue scale affects the reliability and validity of results. Also, as the study was limited to one state in Australia and only physicians were involved as participants in the research, caution should be used when generalising to wider countries and professional groups. However, as there are limited studies providing insight in to the decision-making process, the results add insight to the topic as an area for further enquiry.

Zhu et al (2006) explore the use of a computer algorithm to support clinical decision-making relating to rehabilitation potential of older people and whether this could be more effective than the use of a current standardised protocol. The ‘K-nearest neighbour (KNN)’ algorithm was used to simulate expert clinical reasoning through a sophisticated database to enable comparison against a large number of past clinical cases and compared with the use of a clinical assessment protocol used within the identified sites. The same items relating to physical functioning, comprehension, health status indicators and functional potential were used by both assessments. The findings suggest that the use of the KNN algorithm had lower false positive and false negative rates, therefore making more reliable predictions about whether an individual would make functional gains or maintain the ability to live at home.

In relation to professional roles in the evaluation of rehabilitation potential, many studies outline service delivery models where there is an inpatient assessor (often a physician) who assesses rehabilitation potential and therefore determines eligibility for rehabilitation services (Conroy, DeJong & Horn, 2009; Kennedy et al 2012; Hakkennes, 2012). In other service delivery models, the evaluation of rehabilitation potential may be determined by health insurances with limited involvement from healthcare teams (Putman et al, 2007). Within UK professional guidelines (such as the NICE guideline for Intermediate Care and Reablement), general statements advocate assessment for the need for rehabilitation services and indicate this could be carried out by a range of professionals including therapists, nurses or social workers. Studies which discuss the role or involvement of rehabilitation professionals such as physiotherapy and occupational therapy are fewer in number (Cullen, 2007; Shun et al, 2017) although do highlight involvement worthy of exploration.

2.4.4. Decision-Making – managing risk

It could be understandably suggested that practitioners make decisions about the type of rehabilitation based on assessment and management of associated risks. For example, if a practitioner is considering recommending transfer to an inpatient rehabilitation ward, as opposed to a transfer home with referral to a community rehabilitation team, it is potentially the assessment of the extent to which risks can be managed at home which will heavily influence the decision.

Literature searching revealed a paucity of specific examples of studies exploring the influence of risk and risk factors on decision-making about rehabilitation potential and accessing rehabilitation. However, if decisions about rehabilitation are often linked to a transfer of care, themes from literature about transfer of care and discharge from acute hospitals will have obvious overlap. The management of risk is said to be at the centre of decisions about transfer of care and discharge in an acute hospital context (Atwal, Wiggett & McIntyre, 2011; Huby et al, 2004) and is the focus of research studies and national policy (Goncalves-Bradley et al, 2013; The National Audit Office, 2016).

Whilst it is beyond the scope of this section to present a detailed analysis of this policy and literature, key themes about the influence of risk on transfer of care decisions can be summarised. It has been suggested that the Hippocratic tradition continues to dominate decisions about care transfer within and from acute hospitals, with a risk-avoidant approach of doing no harm being apparent (Moats & Doble, 2006). It is also purported that professionals develop a risk-avoidant approach to their practice in this area because of fear over accountability and blame if negative consequences do arise (Atwal, McIntyre & Wiggett, 2011).

There is a great deal of complexity when considering how conceptualisations of risk, risk assessment and risk management influence decisions about transfer of care and discharge. The focus on early discharge means that patients, families and health professionals have limited time to carry out comprehensive assessments or to fully understand implications, which could potentially contribute to decisions favouring risk avoidance (Moats & Doble, 2006). In the case of older people, and particularly where a person may lack capacity for decision-making, family members may be granted proxy-decision making responsibilities and evidence suggests they may be likely to default to a position of protecting elderly relatives (Moats & Doble, 2006; Denson, Winefield and Beilby, 2012). Literature also suggests that health professionals may default to paternalistic and protective positions, perhaps because resources result in a lack of meaningful alternatives, although coercion is sometimes used to elicit acceptance of the best option (Moats & Doble, 2006; Huby et al, 2004). Huby et al (2004) also highlight that when risks present as difficult to manage within a transfer of care decision, the decision may be delayed or deferred through referral to another service, rather than being explicitly addressed. Add to this the acceptance that risk is a subjective construct (Atwal, McIntyre & Wiggett, 2011; Densen, Winefield and Beilby, 2012) and, similarly to the concept of rehabilitation potential, professional perspectives may vary (Clemens & Hayes, 1997).

2.4.5. Decision-making – allocating finite rehabilitation resources

Although policy makers attempt to provide guidance on how to manage supply of, and demand for, healthcare, the fact that there is theoretically an infinite demand for a free and open service poses critical challenges for all involved. Inevitably, those involved in the day-to-day delivery of care and services are required to make decisions which ration and manage access and utilisation.

Priority setting and rationing is a key component of strategic decision making within healthcare and public health, with high profile examples particularly pertaining to funding of medications and surgical procedures open to evidence-based scrutiny and ethical debate (NICE, 2018). However, of relevance to this study, is the priority setting and rationing which occurs on the frontline of clinical practice; including whether someone should be transferred to an inpatient rehabilitation bed or receive intensive community rehabilitation with outcomes of such decisions potentially meaning another person may miss out. This link between practitioner decision making and rationing at a frontline clinical level is acknowledged in literature (Lipsky, 1980; Vryonides et al, 2015).

Lipsky (1980) proposes that often public servants such as health workers enter their chosen roles with ambitious goals orientated towards beneficence and social justice. They often aim to make decisions which respond to the needs of the individual but in the reality of their practice, they must develop techniques which respond to their service users on mass in order to optimise resource allocation and practice fairly.

Lipsky goes on to suggest that it is the decisions and routines of individual workers and teams, influenced by various factors and pressures, which effectively become the public policies which assist to manage workload and demand. He describes this in his seminal work on ‘Street-Level Bureaucracy’ (Lipsky, 1980), and discusses that bureaucrats practicing in public service roles develop techniques to manage compromises and conflicts over demand, resources, access and worthiness. At best, such techniques help them to provide the best and fairest service under prevailing circumstances and pressures although at worst, the techniques can be open to favouritism and stereotyping.

Allen, Griffiths and Lyne (2004) found evidence of ‘Street-Level Bureaucracy’ in an ethnographic study of resource allocation for adults requiring continuing care and rehabilitation following stroke. They found that, where there were increasing pressures on resources such as funding for care packages or bed availability, staff would renegotiate issues of need and responsibility for care to find an option that was potentially ‘easier’ to deliver and organise, and this did not always coincide with the preferences of patients or families. Examples of easier options included giving the option of family members providing care or equipment, or attempting to reassess and redefine the nutritional needs of a patient because a community care package could not be found to meet the need. Allen, Griffiths and Lyne go on to suggest that challenges were particularly heightened when there was clear differentiation in funding and responsibility between health and social care and attempts to navigate these challenges were not always led by clinical need (2004).

Rationing can happen explicitly in routine clinical practice where identified criteria is used to screen in and out those who may benefit from a service. However, along with the suggestion from literature that criteria to support selection for rehabilitation is not always used in clinical practice (Hakkennes, Brock & Hill, 2011), theorists also recognise that there are challenges for public servants about openness in relation to priorities and rationing. Being open about withholding benefits to some and not others is understandably seen as socially divisive and for clinicians, being seen as withholding rather than care-giving is uncomfortable and counter-intuitive (Scheunemann, 2011; Daniels and Sabin, 1998). For these reasons, the decision-making which supports priority setting and service rationing can sometimes become guarded or implicit.

2.4.6. Decision-making - service user involvement

2.4.6.1. Definitions and characteristics of shared-decision making

Health professionals have a responsibility to involve patients in decisions concerning care and treatment. This is outlined in professional codes of conduct, is an ethically accepted approach to practice and is an integral part of contemporary policy and legislation (HCPC, 2013; DH, 2010). There are several reported benefits of patients being more actively involved in decisions about their health care including reduced anxiety, improved knowledge, reduced conflict with professionals, improved treatment adherence and improved satisfaction (O'Connor et al, 2003; Loh et al, 2007).

In their seminal work exploring healthcare decisions, Charles, Gafni and Whelan (1997) highlight and compare prominent models of decision-making – particularly focussing on the paternalistic model, the informed decision-making model and the professional-as-agent model and comparing them to a model of shared decision-making. The paternalistic model places the patient in a passive role with the physician or professional placed as expert. Examples of this can range from the obvious scenarios of a professional recommending tests or treatments or informing the patient what will happen and when it will be initiated. However, more subtle examples could include a professional providing selective information or options and encouraging patients to take a recommended course of action.

Charles, Gafni and Whelan proceed to discuss the informed decision-making model and the professional-as-agent model, suggesting these two approaches are sometimes misjudged as being similar, or interchangeable, to a model of shared decision-making. The informed decision-making model adjusts the asymmetry between professional and patient, but which results in imbalance in the opposite direction. Here, the patient has ultimate responsibility for the decision and the role of the professional is one of information transfer to enable patients to make decisions which reflect the best scientific knowledge and are aligned to their preferences. Whilst also having an important place within health care, particularly in relation to self-management of long term conditions, research has highlighted that there is a difference between the desire for information and understanding, and the desire for ultimate responsibility for decisions (Ryan, 1992 cited in Charles, Gafni and Whelan, 1997).

The professional-as-agent model reverts back to the professional assuming responsibility for decisions, but with a responsibility to elicit client’s preferences and perceptions in relation to issues such as quality of life, perception of risk and the meaning of health and wellbeing. Again, the contrast with a model of shared decision making is obvious, with responsibility being placed with the professional and reliant on information sharing and giving which may have varying degrees of success.

Charles, Gafni and Whelan (1997) subsequently develop principles of shared decision making which are frequently referred to in more recent research examples. They identify four key principles including: the need for at least two participants; the need for both parties to take steps to participate; the need for information sharing as a prerequisite; and the need for a treatment decision which both parties agree to. Critics suggest that this seminal discussion, followed by more recent definitions of shared decision-making often lack a specific focus on collaborative goal setting although this should be a core component of the concept (Vermunt et al, 2017).

The focus on involvement and shared decision-making in professional standards and health policy has led to attempts to establish the extent to which this is being achieved in practice. Evidence suggests that, despite patients wanting a more participatory role, the majority of patients are still not experiencing a shared approach to decision-making (Dierckx et al 2013). However the challenge of conceptualising what shared decision-making means to different groups and the subjective measures by which it is evaluated are often cited as challenges for practitioners and researchers and raise inevitable questions about trustworthiness and generalizability of evidence.

The reported distance between policy and practice has prompted exploration of strategies for improving the adoption of shared decision-making principles by health professionals although a recent Cochrane Collaboration systematic review found a paucity of studies and resulted in difficulty reaching meaningful conclusions (Legare et al, 2014).

2.4.6.2. Wider concepts – participation, engagement and involvement

More recently, the terms participation, engagement and involvement (among others) have been commonly used to reflect a broader agenda for service users, families and carers to become active participants, not just in decisions, but in care and services in their entirety. Once again definitional challenges emerge, with the terms being used loosely to describe concepts relating to patient actions or behaviours, retention within or adherence to services, self-management of conditions or referring to the interaction between patient and provider, among other uses (Bright et al, 2015).

A recent systematic review on the topic of engagement in healthcare and rehabilitation proposed a definition of engagement as ‘a co-constructed process and state….[which] incorporates a process of gradually connecting with each other and a therapeutic program, which enables the individual to become an active, committed and invested collaborator in health care' (Bright et al, 2015; p 650). Interestingly, out of 28 studies included in the review, the majority of studies were carried out in relation to mental health contexts (with others referring to discipline specific understanding in social work, or speech and language therapy) leaving the understanding in relation to physical rehabilitation a little less clearly developed.

2.4.6.3. Benefits and challenges of involvement for older people

In relation to rehabilitation, participation and involvement often happen within a goal-setting process (Rose, Rosewilliam and Soundy, 2017). Studies have suggested that involvement in a goal-setting process can increase patient satisfaction, improve motivation, and creates a greater sense of ownership of the rehabilitative process (Rose, Rosewilliam and Soundy, 2017). For these reasons, goal-setting is widely discussed as a fundamental part of a collaborative rehabilitation process.

Vermunt et al (2017) carried out a systematic review on the topic of collaborative goal setting with elderly patients with chronic disease or multi-morbidity. Whilst providing some evidence for the health and wellbeing benefits of goal-setting, such as improved functional outcomes, improved motivation and improved adherence to interventions, overall conclusions suggested compelling evidence was lacking. They mainly attributed this to practice variations and methodological challenges, suggesting that goal-setting is often poorly defined and described, and is often part of multi-factorial interventions making it difficult to attribute outcomes to particular elements. They concluded that the review was relevant, yet premature, with conceptual clarity an important pre-requisite.

Despite supporting evidence for goal-setting to contribute to a multi-factorial rehabilitation process, older people are less likely to be involved in goal-setting and decision-making and are more likely to actively or passively relinquish involvement in decisions about care (Schulman-Green et al, 2006; Foss, 2011). Challenges to involvement and shared decision-making specific to an older population are regularly cited, including frailty, sensory impairments and cognitive impairment (Lally & Tullo, 2012). And although some studies highlight a proportion of older people who may not want to be involved in decisions about their health and care (Ekdahl, Andersson and Friedrichson, 2010), authors and researchers warn that it is simplistic and inaccurate to assume a generalised position that older people prefer to be told what to do or to have decisions made for them (Lally & Tullo, 2012; Bastiaens, 2007). A large scale study, involving 406 older people across 11 European countries, highlighted that older people do want to be involved in decision-making about primary health care (Bastiaens, 2007), something echoed by other studies in a range of generalist or specialist health care contexts.

If the view that older people may not want to be involved in decisions about their care is agreed as simplistic, the more realistic and accurate reflection is that the interpretation of what involvement and shared decision-making means is complex. Bastiaens (2007) found that involvement was interpreted by a caring relationship and receiving appropriate information rather than necessarily having a role in decisions themselves. Similarly, and specific to an acute care context, Ekdahl, Andersson and Friedrichson (2010) explored the experiences and preferences of frail elderly patients for participation in medical decision-making in hospital. Qualitative interviews with 15 participants aged over 75 revealed that participation in decision-making was more realistically about effective communication, information giving and the opportunity to be listened to, rather than responsibility for a particular choice.

Although some of the challenges to involvement and shared-decision making involving older people have been noted above, it is perhaps also pertinent to this area of enquiry to acknowledge the challenges with achieving shared decision-making in an acute hospital environment. Such challenges include the dominance of a biomedical model and a Hippocratic tradition which places value on beneficence, the fear of liability and the potential difficulty in offering options due to time and resource limitations (Moats, 2006). There are also valid reasons for diminished abilities to engage in decision-making during acute admissions (Scheel-Sailor et al, 2017).

Data gathered through qualitative interviews with occupational therapists involved in discharge decisions for older people highlighted the prevalence of professionally-dominated decisions in an acute context, and discuss the influence of limited time to work towards true client-centredness (Moats, 2006). The authoritative influence of physicians who can make or override a final decision was also noted in this study.

Lally and Tullo (2012) suggest that, to respond to variation in preference for, and meaning of shared decision-making, the foundation of working towards this for older people should be an attempt to establish the preferred extent and nature of involvement. Bridges, Flatley and Meyer (2010) highlight the difference between power and choice being willingly ‘given up’ and it being ‘taken away’ by professionals in acute care, and discuss the sharing of information to establish whether an individual wants to be involved, and the way in which they would like this to happen, are issues of significance. The principle of information sharing as a pre-requisite, identified in the seminal work of Charles, Gafni and Whelan (1997) underpins this important message.

To develop the importance of information sharing, Huby et al (2004) provide an insightful way to approach the issue of involvement of older people in decision-making, suggesting that rather than looking at autonomy (that is, the person making the decision for themselves), attention should be placed on trust. They go on to suggest that trust is an active decision in itself and for older people making decisions about their treatment and care, this involves a decision to share responsibility for their own welfare with somebody else in situations of uncertainty and risk. For an active decision to trust a professional, Huby et al (2004) summarise that an individual fundamentally needs sufficient information to understand the system of care, which includes open communication about risk, resources and responsibilities.

2.5. Chapter Summary

The literature review has attempted to define and conceptualise key themes central to this research, including rehabilitation, rehabilitation potential, and decision-making. The review has highlighted that despite being a part of a professional lexicon, the term rehabilitation potential is notably ambiguous and judgements lack reference to criteria or structured approaches. However, there are consistently reported patient-elements which may predict those likely to benefit from rehabilitation – such as age, presence of co-morbidities, and severity of cognitive impairment – and these elements influence either formal or informal criteria.

There is a general consensus that rehabilitation for older people is effective in improving functional outcomes. However, on closer examination of research, findings provide broad and general support for the many different models of bed-based, community-based and multi-disciplinary rehabilitation, with wide variances in service provision a reality for patients, practitioners and commissioners.

Across all areas of literature, methodological challenges have been consistently noted. Many areas of research relate to specific clinical pathologies or pathways and many studies relating to rehabilitation decision-making rely on retrospective reflection or hypothetical cases.

Synthesis of these issues has therefore focussed this research to explore areas where there are gaps in knowledge or a need for clarity. Rehabilitation potential, and processes used to evaluate rehabilitation potential, are poorly understood and research which explores this in relation to older people is particularly deficient. There is also a compelling case for research methodologies which enable exploration of decision-making in real-time and in the context in which it occurs. Finally, a focus on roles within decision-making, particularly the roles of professionals outside of medicine, such as occupational therapy and physiotherapy, and the roles of patients and families will add important understanding to such enquiry.

CHAPTER THREE – METHODOLOGY AND METHODS

This chapter outlines the philosophical perspectives and approaches adopted to inform the methodological position of this project. Research design and methods are then discussed and the chapter concludes with an exploration of strategies used to enhance quality.

3.1. Ontological beginnings

Ontology is the study of being, concerned with what is real and the nature of existence (Crotty, 1998). It is an important part of any research that the basic set of assumptions of what can be taken as real are outlined in order for the development and utilisation of methods to be fully understood (Gonzalez, 2000). From the research aim above, it could be suggested that there are certain, perhaps simple, realist assumptions, for example that the hospital system is a reality. However, Crotty suggests that whilst ‘the existence of a world without a mind is conceivable…meaning without a mind is not’ (1998; p11) and it is here where a more constructionist ontology emerges.

Therefore, from this constructionist position, the research is based on the assumption that reality is social in nature and is created through engagement in social relationships and interactions (Alvesson and Skoldberg, 2009). Secondly, there is an assumption that meanings are developed within social contexts and that, irrespective of whether these meanings are held individually or collectively, people will act towards external realities (in this case, act by way of making decisions) based on such meanings (Blumer, 1969). Furthermore, the research also acknowledges boundaries as socially constructed realities; boundaries between professions such as occupational therapy and physiotherapy; boundaries between professionals and patients; and indeed boundaries between the researcher and the research. And finally, there is assumption that the research relies on interdependence between the researcher and the context; in the words of Gonzalez ‘a seed will not grow unless it is planted’ (2000; p634).

3.2. Epistemology

Epistemology refers to the nature of knowledge and is concerned with providing the philosophical basis for deciding what knowledge is possible and how it can be accessed. Social Constructionism offers a starting point to present the philosophical basis underpinning this research. The main premise of social constructionism is that what people know about the world depends on how they approach any given phenomenon, and how they approach it will depend on the social relationships and constructs which they are part of (Gergen, 2009). Furthermore, if ways of knowing and understanding are influenced by social relationships, such ways of knowing, categorising and understanding concepts and phenomenon are also historically and culturally specific (Burr, 2003). People construct ways of understanding through their social interactions and through shared language. And because knowledge and social action go together, the ways in which individuals, groups, organisations and communities act and behave are again socially constructed and framed in a set of physical, temporal, social and political circumstances (Burr, 2003).

A social constructionist paradigm is perhaps in opposition to a more realist paradigm and realist or positivist approaches to research. Social constructionism does not deny that things are real, but instead suggests that when people are defining reality, they are doing this from their own particular perspective; a perspective which has been shaped by the social relationships which have constructed their world (Gergen, 2009). It is such initial insights that create the important alignment with qualitative research.

Qualitative research is appropriate where the issue is emerging, complex or ambiguous (Bowling, 2009). This type of research can not answer research questions about frequencies, effects, causes or strength of relationships but instead can develop understanding of social processes, experiences and behaviours (Barbour, 2014). It is such insights that also underpin a founding epistimelogical position of this research, that knowledge will be created through the understanding of this phenomenon within the naturalistic social context in which it occurs.

Thinking in more depth about social constructionist theory, for individuals and groups it could be suggested that social constructions of reality gain their significance from their social utility and how they can then be used or applied (Gergen, 2009). That is to say, if constructing a shared meaning leads to a perceived positive or satisfactory outcome, then people begin to perpetuate and preserve the shared meaning and the opposite can be seen when social utility is lost or becomes less obvious.

Social constructionist theory does not view knowledge as something held by an individual, but instead is seen as something that is generated within a social context. Utilising principles of social constructionism to inform social research leads to a critical stance towards meanings, language, assumptions and norms, and to examine the social processes which are constructing ways of knowing, thinking and acting. Such foundations begin to offer important theoretical principles for this research; that people will make decisions and take actions based on shared assumptions and norms of what rehabilitation offers and what an evaluation of rehabilitation potential can mean.

However, this viewpoint would also purport that there is little benefit in looking for one-off, once-and-for-all descriptions or explanations as social life and relationships are continually changing and exposed to new and different influences (Burr, 2003). This therefore supports another important epistemological assumption – that the research should involve looking for descriptions and meanings at different periods in time with different contextual influences.

Under a broad grouping of traditions which place value on social reality, Symbolic Interactionism provides further theoretical understandings of the ontological, and therefore epistemological, stance. When attempting to understand Symbolic Interactionism, Blumer (1969) presents regularly cited core principles. Firstly, that people act towards things, including each other, on the basis of the meanings they have for them. Secondly, that these meanings are derived through social interaction and interpretation with others. And thirdly, that these meanings are managed through an interpretive process that people use to make sense of the objects that constitute the world they live in.

It is this suggestion that people act towards things – including other people, objects, and language – that supports an additional important epistemological assumption. Although similar to the broader church of social constructionist research in the agreement that meaning making is a social process, it is the insight that humans can be best understood through what they do. Dewey insightfully captures the essence of this by suggesting that ‘the test of ideas, of thinking generally, is found in the consequences of the acts to which the idea leads’ (1929; p136). Drawing from this, this research will use the vehicle of decisions and actions (decisions about rehabilitation potential and rehabilitation pathways) to closely examine social processes and meaning-making.

3.3. Methodology

3.3.1. Ethnography – the overriding methodology

From a perspective that ways of knowing and acting can be understood as socially constructed, ethnography was identified as a methodology which enables the study of cultural groups in their natural setting to understand the realities of actions within social contexts (Cresswell, 2009) and therefore presented an important starting point. This commitment to a methodological position which placed importance on understanding of meanings and activities within a given 'field', through participation in real time and in the authentic context, embdedded the principles of ethnography as guiding principles for this research.

Ethnography involves the researcher participating in the daily lives of participants, or the daily pattern of a setting, over an extended period of time and collecting a broad spectrum of available data in order to illuminate taken for granted and everyday behaviours, rituals and practices (Brewer, 2000; Hammersley & Atkinson, 1995). Ethnography commits to 'telling it like it is from the inside' (Brewer, 2000; p17). It has also been suggested that it is the way in which ethnography makes links between the micro and the macro, between everyday occurences and wider cultural, social and political influences that is one of the most clear distinguishing features of this methodoloy (Savage, 2006). Importantly, there are contemporary examples of ethnographic research exploring decision-making and care processes in hospital contexts (Poole et al, 2014; Waring et al, 2014).

Hammersley, one of Britains recent and foremost authors on the topic of ethnographic research suggests that it includes the following features:

- People's behaviour is studied in everyday contexts rather than unnatural or experimental conditions created by the researcher.
- Data are collected by various techniques but primarily by means of observation

- Data collection is flexible and unstructured to avoid pre-fixed arrangements that impose categories on what people say or do
- The focus is normally on a single setting or group and is small-scale
- The analysis of the data involves attribution of the meanings of the human actions described and explained

(Hammersley, 1990)

Traditions and branches of ethnography are described in different ways by different authors, such as naturalist, realist, critical and feminist ethnography, among others (Skeggs, 2001; Savage 2006; Schwandt, 2007; Hammersley, 1998). The branch of critical ethnography approaches enquiry from a social-ethical perspective, aiming to scrutinise taken-for-granted social, economic, cultural and political assumptions of societies or organisations (Schwandt, 2007). The insight that critical ethnography often focuses on specific practices within specific institutions (Schwandt, 2007), suggests some alignment with this study.

Organisational ethnography is also discussed within literature pertaining to social research (Gaggiotti, Kostera & Krzywozeka, 2016; Neyland, 2007; Brewer, 2000) although as sociologists understand the term organisation to mean structures which manage and organise life and behaviour, it could be argued that all ethnography is organisational in nature (Brewer, 2000). That being said, organisational ethnography often refers to the study of more formal organisations such as workplaces and institutions and has been identified as an approach to social research which can assist to understand occupational careers and identities, alongside the maintenance of power and control and examples of decision-making within organisations (Brewer, 2000). This last example of organisational ethnography to explore reasoning and decision-making within organisations is particularly pertinent. There are examples of research aligned to the umbrella term of organisational ethnography which explore discretion, rule-making and interpretation of organisational influences when making decisions, and specifically examples researching health professionals operating within institutions and organisations (Becker et al, 1961; Chambliss, 1996).

More specifically, medical ethnography is often seen as a branch of organisational ethnography studying the cultures and everyday pracitces within healthcare systems and workplaces. However, it is also perhaps seen as broader than simply a branch of organisational ethnography, not only taking place within healthcare instituions, but exploring issues of health, illness, and disability across a range of settings, cultures and groups (Bloor, 2001). Influential ethnographic studies within this tradition include the study of 'Asylums' to examine the social construction of mental illness from within an institution (Goffman, 1975), and the culture and socialisation of medical students in the seminal research by Becker et al (1961) entitled 'Boys in White'.

Medical ethnography has been used to explore the meaning of every day or taken for granted phenonena in relation to health and healthcare systems, alongside examining healthcare interactions and professional decision-making. It has increasingly been recognised as a way to analyse inter-professional and intra-professional interactions which create consensual and collective agreements of patients or their difficulties and establish particular courses of action (Bloor, 2001). There are examples of ethnographic research which illuminate how meanings of health concepts such as rehabilitation can be shaped differently for different audiences, and under different social, temporal and organisational influences (Gubrium & Buckholdt, 1982). Furthermore, medical ethnography is recognised as often having a powerful impact on professionals due the rich descriptions of healthcare systems and routines and the accessible links to everyday practice (Bloor, 2001). Features such as this have illuminated the synergy with this research.

Despite recognising positive alignment with the key features of ethnography, there were other perhaps more 'problematic' issues requiring critical consideration. For example, ethnograpy as a methodological position places emphasis on immersion and extensive data collection; an area where I had pragmatic concerns due to time Iwas able to commit to data collection and role-immersion. Opportunities to be flexible, serendipitous and to examine the social world from all angles would indeed need to be boundaried, not just due to time but by the desire to set parameters and stay focussed on specific research objectives.

There are also other methodological positions which place value on lived experience, leading to methods which support contemporaneous data gathering in context. Critical consideration was given to branches of phenomenology to explore the meanings of a phenomenon (namely rehabilitation potential), and the lived experience and emotional response to decisions and actions relating to this phenomenon (van Manen, 1990). Aligned with phenomenology, the use of audio or written diaries, used as adjuncts or alternatives to indepth interviewing, provide methods to capture real-time thinking and reflections (Alaszewski, 2006). However such a position, and the use of such methods, would not have enabled the attention to the wider contextual and cultural influences on reasoning, with emphasis instead placed on learning from individual interpretations and experiences.

Similarities have been drawn between ethnography and grounded theory (Brewer, 2000; Charmaz and Mitchell, 2001) and again this was given consideration. Although often discussed as more of an approach to data analysis, it is also discussed as a methodologyy for developing theory, grounded in data, which is systematically gathered and analysed (Brewer, 2000). Key features of grounded theory include the use of constant inductive analysis to build theory from the ground, theoretical sampling to test theories which emerge from the data on an ongoing basis, and reaching theoretical saturation which describes a process of searching deliberately for understandings until no new data or examples emerge. It is often discussed as informing the development of qualitative analysis software packages such as NVIVO, aiming to enhance objectivity in qualitative analysis (Gobo & Molle, 2017).

Those who recognise the synergy between grounded theory and ethnography suggest principles of both can work to overcome problems if adopting one approach in a more purist sense. To summarise some of the potential benefits, a combined application can lead to more focussed time within the field and assist the researcher to move beyond what is often viewed as unsophisticated description towards theoretical development (Charmaz & Mitchell, 2001). However, others argue that rules and procedures can lead to a constrained analytical lens and more subtle processes are required for teasing out meaning and interpretation (Brewer, 2000). Whilst recognising that some of the structured guidelines and procedures may be of assistance in the case of this research, it was a desire for a more sensitive and naturalist approach to data generation and analysis that encouraged a move beyond this. Also, from a pragmatic view, I was also aware that some of the key features of grounded theory (such as theoretical sampling and data saturation) may not have been easy to achieve in the context of a study requiring rigid ethical approvals alongiside the necessity to comlete data collection within a set time period as a part of a part-time PhD programme. Because grounded theory is built on such principles, and the scientific rigour that this aims to achieve, there was a danger of being left with an unsatisfactory version of this methodology which neither aligned with the strengths, nor answered the criticisms.

Continued exploration beyond the expansive literature regarding ethnographic traditions led to important alignment with case study research. Although some commentators suggest case studies are primarily a method, others suggest the principles communicate more than just a method, instead suggesting that it can be considered as an over-arching methodological position or paradigm which communicates assumptions about the nature of the social world and how that world can be studied and understood (Hammersley & Gomm, 2000). The case study paradigm has an overriding commitment to understanding a case or phenomenon in depth and in authentic contexts and appreciates the case as a bounded entity. Generalising to other cases or examples of a phenomenon is not a primary aim, although rich description and illumination of the features of the case will enable readers and scholars to judge generalisability for themselves (Yin, 2009; Yin 2012). Case studies have been reported as having a central tendancy to illuminate decisions or sets of decisions, why they were taken, how they were reached or implemented and with what result (Schramm, 1971; cited in Yin, 2014) and again, commonalities with this research which aimed to explore decision-making in a healthcare context are apparent.

3.3.2. Research design

Both ethnographic and case study research support the use of multiple data collection methods and a flexible and creative approach to data gathering, in order to look beyond the known and the anticipated and to be able to respond in a serendipitous and adaptable way (Rock 2001; Yin 2009). Rock goes on to suggest that ethnography which attempts to prescribe firm research designs or instruments may result in blinding the researcher to the social world, preventing effective responses to what could be discovered. Although stages and methods of data collection were provisionally planned and indeed, such plans were a requirement of ethical approval and negotiating access, it was also important to approach the collection and generation of data with flexibility and openness.

Although recognising some similarities in the use of multiple methods and the flexible, responsive design, it is also this element of research design where there are differences between conventional ethnographic research and a case study design. Furthermore, it is perhaps here where a pragmatic hybird of principles from both positions was adopted.

3.3.3. Identifying the ‘case’ and negotiating access

Stake (2000) suggests a case is whatever bounded system is of interest to the research. It can be a common or everyday phenomenon, or the case can be an individual, oranisation, process or an event (Yin, 2009; Yin 2012). In this study, the case was initially one ward within one identified institution. However, from the theoretical and empirical picture (illustrated within the literature review), the research aim and objectives expressed an interest in specific health professionals (in this case occupational therapists and physiotherapists) and learning from specific patient examples. In addition, although one ward represented a bounded entity, the boundary between the case or phenomenon and it’s context can be blurred, and therefore the research design needed to take in to account wider physical, temporal, spatial and social dimensions (for example services, professionals or other wards which linked to the main ward). In relation to literature guiding case study design, this has been explained as ‘nested units of analysis’ or ‘embdedded subcases’ within a single case study (Yin, 2012) and therefore the focus on occupational therapists, physiotherapists and specific patient cases could be described as examples of such nested units of analysis within the case of the identified ward and system. It is perhaps through this need to develop pragmatic boundaries around the case and areas of interest where the principles of case study design influenced the research, although the study remained committed to an overarching ethnographic methodology.

Preliminary support for the project was sought through an existing contact (as part of my role as a university lecturer) and through developing a contact with the NHS Trust Research and Development department. Both before and after gaining institutional and NHS ethical approval, an extensive period of meetings (with operational managers, therapy and nursing managers and senior therapy clinicians) took place to negotiate where the research could be situated. These meetings were undertaken with two main aims; to introduce the research sensitively and professionally to key stakeholders and gatekeepers and to narrow down the focus on an identified ward and subsequently a smaller group of professionals. Although presence was initially legitimised through NHS ethical approval and a small number of identified contacts within the organisation, identifying other (sometimes powerful) gatekeepers who could sponsor and legitimise the research was important and is well recognised as a lengthy process in ethnographic research (Pope, 2005). Email contact was also initiated with two consultant geriatricians and although attempts to meet were not feasible due to workloads, it was essential that they did not hear about the research project or developments second hand.

The final decision to identify the ward was strongly guided by service managers. Reasons for this guidance mainly related to stability of staffing and considerations about timing of data collection (mainly linked to movement or rotation of staff). At this point, it was critical that I maintained clarity about the aims and objectives of the research in order to notice and consider how these preferences expressed by managers or services had the potential to shape or drive the research with different organisational agendas or perspectives.

3.3.4. Patient and public involvement in research

Involving the public, including patients, in the planning, design and delivery of research, and not solely as participants, is an explicit and strategic aim of the Health Research Authority (HRA, 2013). I was aware from the outset that I had not encouraged public or patient involvement in the research idea, the generation of the research aim or question or the early design of the project - all recognised as important stages for involvement (National Institute for Health Research, 2012).

Involvement did begin at the stage of ethical approval as there was a service-user lay representative sitting on the NHS Research Ethics Committee panel. To further develop patient and public involvement, I progressed with an intention to establish a research advisory group to aid with planning and implementation, with representation from physiotherapy, occupational therapy and service users and/or carers. I asked for volunteers from the physiotherapy and occupational therapy clinical teams within the Trust but who were not directly involved in the research. A member from each discipline volunteered and were invited to this meeting.

Repeated attempts were also made to partner with a service user and carer representative through contact with the Trust Research and Development Department, the Patient Advice and Liaison Service (PALS) and Service Managers. Despite these attempts, I did not receive any specific guidance on how to contact a service user representative and this group were subsequently not represented on the research advisory group. This was not only disappointing for the project but reflective of accepted barriers to meaningful public and patient involvement, not just in health research, but in health education, policy and indeed practice (Snape et al, 2014).

Instead of delaying the project, I progressed with an initial advisory group meeting where the physiotherapy and occupational therapy representative reviewed research design elements, such as how patient participants would be identified, how I would find out about important professional-patient interactions (in order to be in the right place at the right time), and the process of giving research information and gaining consent. The professional representatives also read examples of participant information and gave feedback. Due to one of the group members subsequently changing roles and becoming more directly involved as a research participant, this group did not meet again.

The issue of service user and carer representation was critically discussed within research supervision, with supervisors encouraging reflection on ways to overcome this. Current approaches to public and patient involvement have been criticised for being tokenistic (Snape et al, 2014) and often driven by a consumerist model rooted in market research which aims to gain feedback in order to improve the product (Ocloo & Matthews, 2016). This reflection assisted me to move forwards and I subsequently moved away from trying to create a one-off mechanism to seek feedback, instead using more naturalistic opportunities within the orientation period of fieldwork to talk to, and involve, patients and carers. I showed copies of information to gain feedback about accessibility of format and information and chatted to patients about whether there were issues they would like to understand further about healthcare decision-making.

From both the advisory group meeting, and the informal collaboration with patients during the orientation stage of fieldwork, there were no major changes to the research design or changes in the direction of the study. However, I did feel that this helped me to prepare for subsequent periods of fieldwork, particularly the period where I would begin approaching patients for involvement as participants.

3.4. Methods

3.4.1. Methods of data gathering

Tradtionally, ethnograhers immerse themselves in daily lives and routines for an extended period of time, gathering structured and unstructured data from a range of sources (Hammersley and Atkinson, 2007). At the outset of the study, it was envisaged that the study would involve four main approaches to generate data; field observations (either focussed on activities such as meetings, or focussed on spaces such as the nursing station or a ward bay), review of secondary data (clinical records), individual observations (of health professional practice and health professional-service user interactions) and individual interviews (with health professionals and service users). However, it was here that the commitment to an overriding ethnographic methodology was influential by emphasising direct observation as the primary method of data collection.

3.4.2. Principles of observation

3.4.2.1. Overt observation

A simple distinction between overt and covert observation is that overt observation is conducted openly and with the researcher's identity being clear to participants, whereas covert observation has not gained full consent and is not conducted with full knowledge (O'Reilly, 2005). However, O'Reilly recognises that the realistic distinction is perhaps less clear with participants potentially forgetting, not understanding the true purpose, or with motivations and interests emerging throughout the process of the research. For this study, I adopted an overt position – introducing myself as a researcher, wearing a name badge identifying myself as such, and providing information both before the research and during the course of research activities to remind participants about the purpose and focus of the research.

3.4.2.2. Participant observation - insider or outsider?

The term 'insider ethnography' was mainly used in the past to distinguish ethnography undertaken in familiar and 'home' settings, in contrast to those who travelled some distance to research cultures, societies and groups who were significantly different to their own (O'Reilly, 2005) However, there has been more recent recognition that this is not only simplistic, but the very introduction of such categories is problematic (Hammersley & Atkinson, 2007).

I reflected on elements which could assist me to move between both positions - as an insider within the occupational therapy profession, and an insider (albeit previously) within an acute hospital system. However, I was aware that I could be perceived as an outsider to other professions, or to current clinical pracitce. I was also aware that some of the choices made during fieldwork would influence this. One significant example was choice of dress – not wearing a uniform and instead wearing a professional dress which adhered to hospital guidelines and with a visible hospital identity badge. This attracted one comment from a physiotherapist during the early stages of fieldwork that I ‘looked like one of the doctors’. Coffey (1999) recognises that the presentation of self and forms of dress can communicate several different subconsicous or conscious positions, potentially declaring affinity or creating distance. I had consciously considered the distance I was creating from clinical occupational therapists and physiotherapists by not wearing a uniform, although the potential proximity to others (potentially medical staff) that this created was unanticipated.

Being aware of proximity to certain groups was something I attended to throughout fieldwork. Ethnographers are encouraged to adopt a ‘marginal position’ (Hammersley & Atkinson, 2007) which strikes a balance between access to participants and opportunities, but minimises the danger of over-rapport. I kept this in mind during fieldwork, for example, although I had an area to leave personal belongings within the occupational therapy department and was required to sign in and out of this department as a health and safety requirement, I deliberately did not visit the department over lunch and break times representing an attempt to draw some boundaries for this group in relation to what consituted an obvservation or a research activity.

Much of the critique of insider and outsider positions has focussed on the potential influence this then has on the susequent research process (Coffey, 1999; Hammersley & Atkinson, 2007; O’Reilly, 2005). Through engagement with this critique, I became more aware of issues affecting this position, aiming to maximise the advantages of both which would provide opportunities for acceptance and shared understanding, whislt maintainng objectivity. O’Reilly insightfully summarises this, encouraging ethnographers to embrace the tensions of moving between insider and outsider and using this to strive to make the familiar strange, and the strange familiar (2005; p98).

3.4.2.3. Level of participation during observation

The level of participation was something I needed to consider and plan before entering the field, something that was required for the process of ethical approval. Initially, parallels were drawn with the concept of ‘passive observation’ (Spradley, 1980; p59) which mainly involved being a spectator within social situations, finding unobtrustive and detached positions, both physically and emotionally. This was mainly with the well-intentioned, although perhaps inexperienced, motivation of keeping any influence on patient care to a minimum, and many examples of observations in the early days of fieldwork (particularly in the orientation phase) were charachterised in this way.

The process of ethical approval encouraged me to plan for situations where I may be required to take a more active role. I was encouraged to prepare for situations such as observing an unsafe moving and handling situation, or becoming aware of a safeguarding issue. I was therefore aware that instances such as this may increase participation to ‘moderate’ or ‘active’ participation (Spradley, 1980) and that insider elements of my role such as my own Code of Ethics and Professional Conduct (Royal College of Occupational Therapists (RCOT), 2015) and my awareness of safeguarding legislation would mean I may need to intervene within such observations. Part of this planning included the identification of a ‘line manager’ within the organisation to whom I would report such issues and seek support.

In reality, some of these more extreme examples of participation did not emerge. However, what did emerge was that participation moved beyond a passive role in many less obvious ways. For example, I found myself moving obstacles when observing a physiotherapist mobilising with a patient, covering patients with blankets which had fallen on the floor, or pushing the notes trolleys back to the ward after a multi-disciplinary team (MDT) meeting. Coffey (1999) recognises fieldwork observations as an inevitably embodied activity, and that performing parts of the roles of those being observed is an important part of the whole sensory experience.

This move from a more passive to a more active role encouraged me to tune in to my influence within the field and encouraged me to consider issues of reciprocity; that is the extent of my involvement in give and take (Baumbusch, 2010). I considered that I was asking participants to share time, experience and reasoning with me, and reflected on the extent to which I could give things back that could assist their own practice. Whilst doing this in small ways (such as carrying things for them, or returning trolleys to the ward after a meeting), I needed to carefully recognise when this could pose risk. For example, on one occasion it was highlighted that there would be no occupational therapy representation at a meeting and a team member asked whether I could take notes for them. I needed to consider the risks of this activity (for example if I gave inaccurate information), the interruption to the status quo (who would take notes for the absent team member on any other occasion?), and importantly when it would detract from the focus of my own observations.

3.4.3. Phases of data gathering

3.4.3.1. Preparatory phase – relationship building, negotiating access and consent

The extensive period of negotiating access outlined above was also a foundation for subsequent data collection stages. It is recognised that the relationships built with people during the early stages of ethnographic research can have important consequences for way the research subsequently develops (Hammersley & Atkinson, 1995). Ethnographers need to trust those they are working alongside and vice versa

(Brewer, 2000) with people in the field often being more concerned with what kind of person the researcher is, rather than the research itself (Hammersley & Atkinson, 1995).

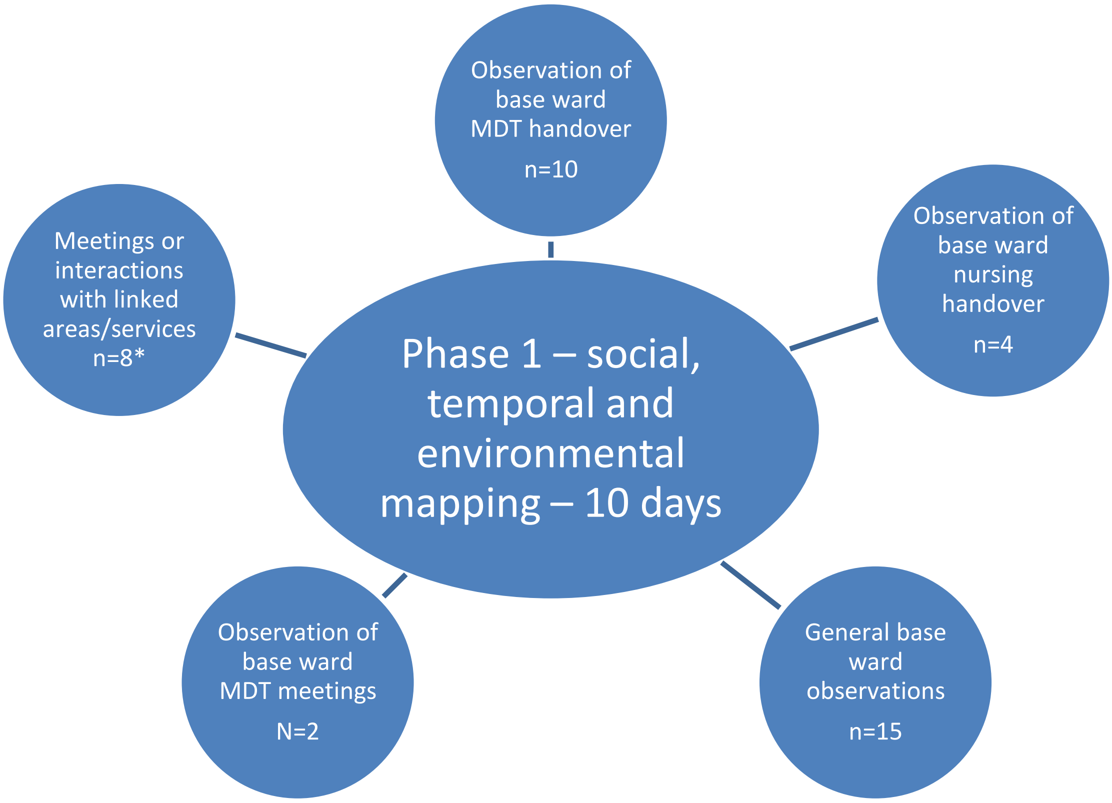
In the weeks preceeding the beginning of fieldwork, I visited the base ward on several occasions, mainly under the premise of meeting key people and gaining written consent for observations. I also completed mandatory training which was a requirement of the organisation (such as information governance, good clinical practice in research and infection control), further legitimising my position and helping move from the position of ‘outsider’. Whilst having practical reasons helped to legitimise my presence, it also helped me to consider other elements which had yet to receive consicous attention, such as dress code. This time was an important time in making the transition from ‘outsider’ and ‘visitor’ to ethnographic researcher.

Following this preparatory phase to negotiate access and to build relationships, there were then three main phases of data gathering which are discussed in detail below.

3.4.3.2. Phase 1 – orientation and social/environmental mapping

This first phase of fieldwork was carried out over a 2-week period in May 2016 with the purpose of developing an understanding of roles, processes and an orientation to the physical, social and temporal environment. As per the research protocol, I then came away from the field for a period of 1 week to differentiate between the different phases. A summary of the activities undertaken in this 2-week period can be seen in Figure 1.

Figure 1: Summary of activities during phase 1 of fieldwork



*Included attendance at 3 'Length of Stay' meetings, time spent with members of the occupational therapy and physiotherapy teams outside of the immediate ward therapists, and time spent with other services including a representative from a community reablement service, a therapist from the local intermediate care unit, a representative from a hospital based team who facilitated hospital transfers and discharges, and time spent with a bed manager.

3.4.3.3. Phase 2 – ethnographic fieldwork centered on 'patient tracking'

The next phase of fieldwork subsequently took place over an 8-week period between May and July 2016. A patient-tracking approach (adapted from Waring et al, 2014) was utilised whereby five patients were recruited and consented to be involved in the study and fieldwork activities such as observations of health professionals, attendance at meetings and review of clinical documentation focussed on the identified patients.

The two main aims of this patient-tracking approach were to provide a structure to move from more generalised observations during phase 1 to focussed observations during phase 2, and to also to give a central position within the research to the patient journey and experience. Awareness of both of these areas was developed through engagement with relevant literature. The problem of what and how to observe is regularly articulated in relation to ethnographic and case study research (Gobo & Molle, 2017; O'Reilly, 2005) with whole texts dedicated to attempts to give structure to the process (Spradley, 1980). Alongside this, the case for service user involvement as a central tenet for the research was strong.

Activities and interactions which contributed to data collection during this period of fieldwork are summarised in Figure 2. This included 10 short interviews (or reflexive interactions) with health professionals about one or more of the identified patients.

Figure 2: Summary of activities during phase 2 of fieldwork

3.4.3.4. Phase 3 - in-depth interviews with health professionals

Following a period of initial familiarisation and analysis of emerging themes, the final stage of data collection involved in-depth semi-structured interviews with five health professionals, carried out between April-May 2017. Interviews ranged in length from 40 minutes to 80 minutes, and all were conducted in private rooms away from the clinical area. The outline structure was developed after an initial period of data analysis following phase 2 and on further consideration of the study aim and objectives. An outline of the questions can be viewed in Appendix 1.

3.4.4. Sampling and recruitment

3.4.4.1. Recruitment of patients during phase 2

Using principles of purposive sampling, and adapting an approach described by Waring et al (2014), inclusion criteria for patient tracking was used (and outlined in Figure 3) to guide the recruitment of patients at this stage:

Figure 3: Inclusion criteria for recruitment of patients during phase 2 of fieldwork

Inclusion criteria to identify patients:

- Over 65
- Treated in the identified ward of the acute hospital for an unplanned admission
- Current functional level below pre-admission functional status as determined by the healthcare team
- Medically fit to be approached to participate as determined by the healthcare team
- Able to hear and speak to respond to interview questions

In addition, and utilising principles of theoretical sampling in order to facilitate exploration of emerging issues from the review of literature, additional criteria were also developed (Figure 4) with the aim of sampling people with different experiences of healthcare decision-making.

Figure 4: Additional inclusion criteria for recruitment of patients during phase 2 of fieldwork

Additional criteria:

- At least 2 participants aged 85 or over;
- At least 2 participants between 65-84
- At least one participant with cognitive difficulties (as determined by asking the health care team at initial screening)

Attendance at MDT morning handover meetings and weekly MDT meetings was the main means to identify patients, with subsequent follow-up discussions with the healthcare team utilised to determine appropriateness to approach to participate in the research. As almost all patients admitted to the base ward could have been potentially appropriate for the research, final decisions were based on the recommendations of the healthcare team and to allow exploration of cases with different features.

Initially, it was proposed that only one patient would be involved at any one time to enable research activities to focus on their specific experience and journey, potentially visiting different wards and services across the pathway. However, due to pragmatic limitations such as time, availability and the desire to become involved in potentially rich patient cases, in reality there was some overlap of tracking more than one patient at one time. But once again, decision-making about which participants to approach was made on review of how many other patients were involved at that time. For example, although many patients met the study inclusion criteria, they were not approached to participate as I did not feel I could dedicate sufficient time to their patient tracking at that particular time.

Throughout this 8 week period, 7 patients were approached to participate and 5 patients (or family members) provided consent. A summary of these cases is provided in Table 2. Reasons for not wanting to participate in both cases related to patients not wanting to be involved in (or in the words of one participant, ‘can’t be bothered by’) what they perceived as bureaucratic processes – presenting as being deterred by lengthy information or consent forms.

Table 2: Summary of patients recruited for patient tracking

Patient	M/F	Age	Social Situation	Reason for Admission	Pathway before base ward	Length of Stay on base ward	Pathway after base ward	Total length of stay	Other
1	F	94	Lives with daughter	Aspiration Pneumonia	1 day at emergency care hospital	24 days	27 days on rehabilitation ward. Died on this ward	52 days	
2	F	89	Lives with son	Fall at home and increased confusion	1 day at emergency care hospital	7 days	Transferred to rehabilitation ward. Still on rehabilitation ward at end of fieldwork (after 29 days). At this point, decision made for 24 hour care.	>37 days	Patient deemed to lack capacity to consent
3	M	76	Lives alone	Scrotal abscess Admitted to hospital with regional specialism	40 days at out of area hospital	25 days	N/A – died on base ward	25 days (+ 40 days out of area)	
4	F	79	Lives with son	Pneumonia	6 days at emergency care hospital	9 days on base ward	Discharged home with family support. Recommendation of care package although declined	15 days	Readmitted 3 days after discharge -died during subsequent admission
5	M	80	Lives with wife	? Seizure, ? worsening of Parkinson's Disease, ? Stroke	1 day at emergency care hospital	22 days on base ward	Transferred to rehabilitation ward. 14 days on rehabilitation ward and discharged home with follow-up reablement package	37 days	

3.4.4.2. Recruitment of health professionals during phase 2

During the preparatory phase and phase 1 of fieldwork, I attempted to anticipate which health professionals would be most directly affected by patient tracking fieldwork activities and had gained written consent from many of these staff for their practice to be observed and to be present during their interactions with patients. In the main, this affected physiotherapists and occupational therapists, but also involved nursing, social work and medical professionals.

It was explicitly stated in the research proposal and ethical approval that full written consent for everyone who may be present during a research observation was unrealistic, mainly due to the use of temporary staff within hospital wards and the transient nature of some roles (for example, a nurse visiting from a mental health liaison team). Issues of consent pertinent to this are outlined in section 3.6.8.2.

3.4.4.3. Recruitment of health professionals during phase 3

Utilising principles of purposive sampling, seven health professionals (4 occupational therapists and 3 physiotherapists) had emerged as significant contributors during phase 2 of fieldwork and had already provided full written consent at that stage. On return to the field at this stage, it was established that one occupational therapist had since left this role within the Trust. Six participants were approached to be involved in this stage, with five - three occupational therapists and two physiotherapists – progressing to giving consent to be involved. One physiotherapist did not respond to requests for involvement.

The occupational therapists and physiotherapists interviewed were all either in Band 7 (‘Highly specialist’) or Band 6 (‘Specialist’) roles and, during phase 2 of fieldwork, had a primary remit to deliver services to either the base ward or the rehabilitation ward (although roles had subsequently changed for some staff). One participant was male and four were female. As some of these idiosyncratic details (such as grade and gender) could potentially identify individuals within the organisation, detailed information or characteristics about participants is deliberately not presented. This however does subsequently limit the ability to discuss the influence of gender, experience or length of service in relation to the research findings.

3.4.5. Types of Data

3.4.5.1. Fieldnotes from observations

Fieldnotes are acknowledged as the main means of recording observations in ethnography (Hammersley and Atkinson, 2007). There are many ways to approach this important activity and there are not necessarily pre-determined approaches or techniques (Brewer, 2000; Spradley, 1980; Hammersley & Atkinson, 2007). And whilst essential to the quality of the research, taking contemporaenous fieldnotes has been recognised as an activity which influences the social setting, can be obtrusive and can affect a researcher's ability to engage in true participant observation (O'Reilly, 2005; Brewer 2000). Before entering the field I generated a list of elements to attend to during observations and when completing fieldnotes (Appendix 2).

Becker et al (1961) suggests that it is a good starting point to note everything – the mundane as well as the interesting – and in particular, fieldnotes developed during phase 1 were largely descriptive and concrete, noting many elements during observations such as time of day, people present (and not present), noises and interruptions, physical layout, amongst many other things. Some early field-notes also included diagrams – such as an illustration of the physical layout of the ward environment. Through immersion in the environment, developing during phase 1 and continuing in phase 2, other elements such as interactive patterns, language, and signs of beliefs, values or motivations were added to the layers of information (Spradley, 1980). An extract from fieldnotes is included in Appendix 3.

Some of the above information was captured in short-hand in real time, although at some point during every day short-hand notes were then translated and developed in to long-hand. Care was taken to attribute information to different participants where possible, using quotation marks where I was confident of exact recall, or simply attributing ideas to people where substance was recalled although exact detail was not (Lofland et al, 2006). At this long-hand stage, I also included initial analytic ideas, and personal reflections although again, took care to identify these elements as such. These two different types of fieldnotes – that is the short-hand type produced in the participatory context, and the long-hand often completed in non-participatory, reflective (and often solitary) contexts – are a recognised part of documenting ethnographic research (Madden, 2017).

3.4.5.2. Written data sources

Daily handover sheets and the review of clinical records also contributed important sources of data. Clinical records could not be removed from the clinical environment and therefore similarly to the process of generating fieldnotes from observations, fieldnotes were also made when reviewing clinical records, noting timings, chronology, and written language and expression used by different contributors.

The daily handover sheets were anonymised and stored as an additional source of data, mainly providing contextual information about bed status on each day, numbers of planned discharges, an overview of dependency of patients, and written language used to handover information during meetings. Supplementary information about discussions within the handover meeting were added in short-hand to the handover sheet and then again, integrated in to long-hand fieldnotes. During phase 1, referring to the daily handover sheet was used to assist with socialisation to the setting (for example understanding terminology, abbreviations, contributors), although as the research progressed in to phase 2, I then used these sheets to provide focussed information relating to the patients involved in tracking, or the handover of information pertinent to emerging issues of interest.

3.4.5.3. Interviews and reflexive interactions

During phase 2, short interviews were carried out with health professionals to discuss aspects of their involvement and decision-making in relation to identified patients being tracked. Although these interactions could be perhaps termed short interviews, they were often used to describe routine ways of seeing and doing, and to make visible the usually taken for granted and have been described in other ethnographic research as reflexive meetings or interactions (Liberati, 2015). During phase 2, 10 short, unstructured reflexive interactions were carried out with five different occupational therapy and physiotherapy professionals, eight of which were audio recorded and subsequently transcribed. Reasons for not audio-recording two of these short interviews was due to them taking place in an ad-hoc, spontaneous way which was not conducive to recording. However, long-hand notes were written immediately after these interviews. During phase 3, the five in-depth interviews were all audio-recorded and transcribed verbatim.

3.4.6. Data Analysis

There are many different types of qualitative data analysis aligned to differing theoretical and epistemological positions and providing a range of frameworks, approaches and tools. Examples include Conversation Analysis, Narrative Analysis, Discourse Analysis and Interpretative Phenomenological Analysis. In addition, insight was developed (and discussed on page 60) to the systematic approach to data analysis supported within the tradition of grounded theory.

After considering a wide range of approaches, thematic analysis (adapted from Braun and Clarke, 2006) was chosen as the analytical method in this study. In comparison to other forms of qualitative data analysis aligned to particular traditions, thematic analysis is often seen as a more general approach, compatible and sharing principles with, a wide range of theoretical positions. It has been defined as ‘a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes [the] data set in detail…and interprets various aspects of the research topic’ (Braun & Clarke, 2006). It was this over-arching desire to identify, report and interpret patterns which informed the use of thematic analysis within this project.

As part of the data collection method was organised around patient journeys (the method of ‘patient-tracking’), a biographical form of analysis – such as narrative analysis – to report the ‘stories’ of these cases, was considered. However, narrative analysis is recognised as placing scrutiny on the structure and content of individual cases and stories (Silverman, 2014) and this was not the focus of the research aim or objectives. Adapted principles of narrative analysis were integrated in to the overall approach to thematic analysis (in that examples from the entire data set were pulled out and related to individual patient cases), however a purer form of narrative analysis had the potential to become reductionist and detract from the core and wider focus of decision-making. A more general approach to thematic analysis instead helped to give attention to themes and patterns across the whole data so as to reflect and represent the context as a whole.

The wide use, compatibility and resultant flexibility of thematic analysis is seen perhaps as one of the significant strengths, alongside one of the most important challenges to address. One area of criticism of thematic analysis is that it can be poorly demarcated in published work, with a lack of agreement about what it is and how to do it, and limited levels of detail in relation to decision making guiding analysis. To counter this challenge, Braun and Clarke (2006) provide a comprehensive and regularly cited guide for performing thematic analysis which has provided an outline framework for this project.

Firstly, Braun and Clarke suggest researchers reflect and respond to a series of questions to clarify their analytical position and reflective responses to these questions, originally prepared to discuss this position with supervisors, are included in Appendix 4.Subsequently, Braun and Clarke offer a framework to guide the steps of analysis, summarised in Table 3.

Table 3: Stages of data analysis (continued overleaf)

Stage	Examples
1. Familiarisation with the data	Extensive time spent whilst in the filed re-reading short hand notes, translating to long-hand field notes and adding analytical notes and reflections Critical reflection in research supervision between phases 1 and 2, and phases 2 and 3 to assist with sense-making Cataloguing and annotating field notes throughout – page numbering, cataloguing episodes in relation to patient tracking, and annotating with questions and memos Transcription of audio-recorded data
2. Generating initial codes	Initial codes included: - Meanings - Roles - Decisions - (Patient) Cases/Stories New catalogue of units of data in relation to initial codes Reviewing whole data set in light of research aims and objectives – for example (sometimes referred to as structural coding (Guest, MacQueen, & Namey, 2012) : - Examples of the use of the term ‘rehabilitation potential’ - Examples which illustrate the decision-making process - Examples relating to shared decision making

	- Examples relating to physiotherapy - Examples relating to occupational therapy Reviewing whole data set with reference to other interesting features – for example reoccurring language. Further catalogue of units of data in relation to structural codes
3. Searching for themes	Emergent themes included: - The meaning of rehabilitation - The meaning of rehabilitation potential - Decision making… …about rehabilitation potential …about the rehabilitation pathway …with patients and families
4. Reviewing themes	Use of data clinics within supervision Recognition of the importance of understanding the concept of 'Rehabilitation' before understanding 'Rehabilitation Potential' (unanticipated and an example of 'thinking flexibly' discussed by Lofland et al, 2006). Recognition of ethical dimensions of rehabilitation decision making and the impact this was having on professionals Re-review of whole data set in relation to above
5. Defining and naming themes	1. Descriptions 2. Social Construction and meaning -making 3. The ethical dimensions of rehabilitation decision making 4. Professional roles in decision making

To summarise the table above, the analytical process began immediately through translating short-hand notes in to long-hand notes which also included researcher reflections and analytical memos. Any audio-recorded interviews (both the short interviews during phase 2 and the in-depth individual interviews during phase 3) were also personally transcribed as soon as possible after the interview to enable immersion and early analysis of this data. This was integrated in to a full data set with other examples of secondary data (such as documentation from daily handover meetings) and catalogued firstly in chronological order, and then secondly, in relation to the five patient cases.

Adopting a deductive or theoretical approach to coding, (Braun and Clarke, 2006), I then coded the full data set using codes firstly generated from the research aim and objectives. A further process of structural coding then took place. The codes developed at this stage are outlined in Stage 2 of Table 3. Examples of early coding and theme development can be found in Appendix 5.

Stages 3-5 outline the development and refinement of four overarching themes. This process evolved through ongoing immersion with the full coded data set, and was supported by elements of analyst triangulation with research supervisors outlined in the section below. The four themes are discussed in detail in chapters four-seven.

Computer assisted tools to aid data analysis were considered (for example the software package NVivo) and particularly had potential to assist to organise, categorise and code a large data set. However, as all fieldnotes were handwritten, the task of transposing this to electronic records would have been time-consuming. Instead, I utilised my own manual approach to organising and categorising the data set, which enabled early and ongoing immersion in the data.

3.4.7 Methods to write and present findings

The process of writing and presenting qualitative, and more specifically ethnographic, data is the topic of much debate (Brewer, 2000). However, from reading methodological guidance and example ethnographic studies, key features were identified as methods to aid writing and presentation and will be utilised within subsequent chapters.

Firstly, thick description of context and generic topics are common in ethnography, including physical settings, key individuals, key activities, schedules and patterns of order (Brewer, 2000). These principles have been utilised within the analysis of the theme ‘Descriptions’ and the subsequent writing of this chapter (chapter four). Additionally, because the base ward was the primary ‘case’ or unit of analysis, a thick description of this enables a detailed understanding of context and assists the reader to substantiate analysis and interpretation in subsequent chapters.

Embedded cases of individual patients and professionals are described in part, although instead of devoting lengthy descriptions or sections to these cases, chapters have instead been dedicated to cross-case themes. Information from individual cases have been dispersed across chapters and supported by abbreviated vignettes (Yin, 2014). The use of short vignettes is supported as a technique to pick out specific players or events and written up for special description in order to present a micro-analysis of an identified feature within the data (Brewer, 2000). Vignettes (placed within text boxes within the presentation of findings) were chosen because they exemplified particular phenomena at the centre of the identified part of the analysis.

Another principle embedded in the presentation of findings include the use of verbatim extracts, paraphrasing or reported speech (Woods, 1999). From discussions with patients and health professionals during all phases of fieldwork, I have either been able to present exact verbatim extracts (from transcribed audio recordings) or extracts from fieldnotes (although acknowledging such extracts are open to recall-bias and my own interpretation in fieldnotes). Exact verbatim extracts also have the additional benefit of presenting findings using the natural language of the culture, another important feature of ethnographic writing (Cresswell and Poth, 2018). The different ways of presenting such extracts are outlined on page 102. Such extracts were selected in order to illustrate breadth (where themes or topics occurred across different players, different activities or at different points in time), whilst also selecting more lengthy extracts for purposes of quality and detail (Woods, 1999).

3.4.8. Methods to strengthen the quality of ethnographic research

After long resistance to adopting terms such as validity and reliability in qualitative research, there is general agreement that such terms about whether methods achieve their desired aim, and whether findings are what they claim to be, do not cross over easily to researching the social world. Some question the need to assess the quality of qualitative research in the first place, and therefore deem the principles or terminology a distracting irrelevance. Instead, they suggest acceptance that there are no standards by which claims to knowledge can be judged and knowledge generated through qualitative research should simply be accepted as one account within multiple possible realities (Hammersley, 1998).

For those who feel quality standards are a necessary part of qualitative research, replacement terminology has led to multiple adaptations and new proposals, with credibility, truthfulness, relevance, plausibility, representativeness and legitimacy all being mentioned (Hammersley, 1998; Silverman, 2000; Brewer 2000; Gobo & Molle, 2017). This seems to add unnecessary complexity to an issue which should be relatively simple; to what extent can the researcher satisfy participants, readers and scholars that the representation of the social world reflects an accurate version of reality. I have chosen three concepts of credibility, transferability and relevance which offer explanatory frameworks for many of the strategies used to ensure quality within this study.

3.4.8.1. Credibility

Concepts of credibility have arisen from the counterpart in the positivist paradigm of validity, the extent to which the account accurately reflects the phenomenon it represents (Hammersley, 1998). It is also closely linked to the concept of truthfulness, although this term is yet again controversial within interpretivist research for being based on an assumption that a ‘truth’ exists (Gobo & Molle, 2017).

O'Reilly (2005) suggests that ethnographers are traditionally good at dealing with issues of credibility – due to the ongoing nature of engaging with subjects and developing areas of enquiry as the research unfolds. During this process, participants will often, sometimes subconsciously, point out misunderstandings or misrepresentations, and guide the researcher back to their own lived experience. Within the context of this research, strategies to enhance credibility included the importance of voice, the use of triangulation (both of method and of researchers), member checking, and a clear audit trail to understanding decision-making.

Voice

Constructivists embrace subjectivity and aim to deeply understand specific cases within particular contexts. To do this, it is important to give proper emphasis to the voice of participants in order to represent the phenomenon in the words of those who directly experience it and to take seriously the responsibility to communicate authentically the perspectives of those encountered during the research process (Patton, 2015). During fieldwork, I utilised a voice recorder wherever appropriate and if not, tried to develop sufficiently detailed fieldnotes which enabled words to be captured, or perspectives to be clearly attributed to particular people within the field. In the subsequent reporting of findings I have presented verbatim extracts wherever possible and even when recall may have hindered the use of exact words, have attempted to attribute statements and perspectives to participants.

Triangulation

Triangulation, can involve using multiple data collection methods, collecting data at multiple points, or utilising multiple researchers in data collection, all with the intention of gaining a multi-dimensional view of the phenomenon. This is one of the proposed strengths of ethnographic research in that it openly encourages triangulation of methods, researchers and theoretical frameworks (Brewer, 2000). Looking at the social context using different methods and lenses, is seen not as a way of influencing validity, but as an alternative to validation (Denzin & Lincoln, 1998a).

Methods of observation and interviewing, alongside the use of reference documentation such as medical records and handover sheets were seen as a way of gaining the most rounded picture of the social context and reality and are all recognised as common methods in ethnographic and case study research. Indeed, it is the spontaneous way in which the researcher can move between research methods, providing creative methods of triangulation in order to look in to new interests or provide new perspectives on existing interests (Denzin & Lincoln, 1998b) that is seen as a particular strength of this research. If interest was raised on a particular issue during a patient interaction for example, I could then examine the clinical record to look at how this had been documented, or ask a health professional a particular question about this in a short interview.

An important aim of the use of in-depth interviews during phase 3 was to look again at the issues under exploration in order to provide different dimensions and understandings at a different point in time, and therefore utilised to triangulate between data sources. Although perhaps a little simplistic, comparisons can be drawn between Schön’s model of ‘reflection in action’, and ‘reflection on action’ (1991) where interactions initially took place in real time and in context (during phase 2), and then retrospectively and in an environment away from the site of fieldwork (during phase 3). Perhaps in an ideal world, I would have liked to have been able to explore ideas from data analysis through further and more extensive periods of fieldwork. Undertaking a further period of patient tracking, or carrying out further patient tracking following the period of organisational change, were both considered and discussed within supervision, although were primarily restricted by pragmatic workload demands of carrying out a part time PhD alongside a full time role.

Finally, analyst triangulation was also employed - a method whereby multiple analysists are used to review findings (Patton, 2015). During fieldwork, I discussed early fieldnotes within supervision meetings in order to assist with initial analytical processes. At later stages, supervisors also independently reviewed anonymised interview transcripts and developed their own coding suggestions and analytical notes to share and pose questions. Although recognising that such meetings did not happen regularly and supervisors could not achieve the level of immersion required if carrying out full data analysis, the role of 'critical friends' has been noted as an important role which can be performed by people who fully understand the context of the work but can ask provocative questions and examine work through an alternative lens (Patton, 2015). Notes from such processes were included in data analysis.

Member-checking

Member-checking is proposed as a strategy to work towards credibility and truthfulness by revisiting descriptions and meanings with participants and reflecting on how they understand and respond to the researcher's construction of these concepts (Gobo & Molle, 2017). Alongside a way of extending the data, the phase 3 interviews were also utilised as a form of participant validation or member-checking to strengthen credibility. Themes from the initial analysis of the data were discussed with participants to encourage reflection on congruence, resonance or to open up issues for challenge. Critical consideration was given to the outline of the semi-structured interview schedule (Appendix 3) and discussed in depth within research supervision to place emphasis on co-interpretation rather than looking for agreement or validation, which can sometimes be seen as a danger of member-checking.

Audit trail

Throughout this thesis, and particularly within this Methodology and Methods section, I have presented information about decisions made and activities undertaken with supporting justification. This links to the concept of dependability, and underpins credibility, in that it is the researcher's responsibility to convince the reader that the process was logical, traceable and documented (Patton, 2105). Examples have also been provided within appendices for the audience to also view examples of fieldnotes, interview schedules and stages of data analysis.

3.4.8.2. Transferability

Qualitative researchers have long faced the challenge that they cannot claim to generalise without the inbuilt features of quantitative research, mainly relating to sizes of samples (Gobo & Molle, 2017). Some create distance between qualitative research and the idea of generalisation (Denzin, 1983), while others recognise there is merit in discussing qualitative generalisation, often using the term transferability (Gobo & Molle, 2017).

Firstly, I hold the belief that instances and situations observed during one local context are of interest in their own right and therefore claims about transferability are perhaps less important than the account holding value for this context. However, Gobo & Molle (2017) suggests that knowledge manifests in particular ways in local situations and it could therefore be hypothesised that, with sufficient knowledge of that local situation, an audience can make a judgement whether this knowledge may then apply to situations with shared characteristics. I have therefore attempted to describe in detail some of the features of this local context for people to judge how this knowledge could be transferred to wider settings. Also, because many of the issues are not unique to the local context (such as issues pertaining to hospital use, ageing populations and financial pressures to name but a few) where appropriate, tentative suggestions are made about issues which may affect wider groups, disciplines or organisations.

3.4.8.3. Relevance

Hammersley, a leading author in qualitative ethnographic research, suggests that one of the main standards by which ethnographic research should be judged is that of relevance (1998). He recognises this as perhaps a lesser talked about criterion although discussed that whether the research is of actual or potential relevance should be a primary concern of researchers. This links to concepts of usefulness and originality cited by other authors (Charmaz, 2006). Within this, Hammersley suggests there are two main aspects for a reader to judge; the importance of the topic and the contribution of conclusions to existing knowledge (1998).

It was the purpose of the background and literature review section to outline the importance of the multiple layers of this topic, and the rigour of a research process – in this case a PhD research process involving ethical approval, supervision and annual progression points – to ensure I revisited this issue with regularity and confidence. It is also the purpose of the literature review to illustrate a picture of what is already known, and the purpose of the discussion and concluding sections to explore relationships to existing studies in an accessible way. However, researchers and readers alike must take care not to associate the level of contribution with the extent to which findings confirm or contrast with existing knowledge. Particularly relevant for social constructionist researchers, the commitment to deep understandings of specific and localised contexts should not be forgotten (Patton, 2015), and should not confuse this with a wider search for relevance (Hammersley, 1998).

Whilst the overall case for relevance is yet to be read, and will develop through the subsequent discussion of findings, interpretations and conclusions, another insightful although perhaps less obvious way to consider relevance links to the concept of praxis. Praxis refers to the transformative power of the research and the researcher, and the relevance this had for the practice area (Baumbusch, 2010). Baumbusch recognises that the presence of the researcher can contribute in small and incremental ways to either individual, service or team development and that having the clinical background to appreciate this is an important component.

There were a number of instances where I did feel that participation within the research was having a contemporaneous impact on practice. On one occasion, after a research discussion about their involvement with a particular patient, one physiotherapist commented on how interesting it was and that ‘he might do a reflection on it’. And another participant, at the end of the phase 3 in-depth interview concluded:

> “…Because you don’t really think that you’re doing all of these things as you’re doing them. But when you talk about them and you reflect them, it is quite in-depth isn’t it…it is a lot to think about (laughs)” (I4, Line 352).

Although I cannot make causal claims that my research involvement led to such reflections, or that this reflection may not have occurred irrespective of participation in the research, I could not help but feel that engagement in the research process was emphasising the importance of reflective processes. As reflective processes are linked to learning from experiences and looking for alternatives (Howatson-Jones, 2013; Johns 2013) and have been linked to quality within health care practice, this was a salient issue linked to relevance.

3.4.9. Ethical Considerations

As in any research, ethnographers have a responsibility to protect research participants from harm, placing participant rights at the forefront of research endeavours (Gobo & Molle, 2017). When conducting research in healthcare settings, initial activities are often centred around gaining necessary ethical approvals meaning that considerable time and attention is given at this early stage to anticipating ethical issues and outlining how they would be addressed if they arise (Goodwin et al, 2003). Detail in this next section outlines the development of such processes in relation to anticipated ethical dilemmas and issues, alongside discussion of those dilemmas that arose spontaneously.

3.4.9.1. Ethical Approvals

Ethical approval was initially granted by my own institution (Appendix 6), and subsequently, following submission of extensive supporting documentation (particularly attending to issues of involving vulnerable people as research participants and presenting a protocol which met requirements for clarity but also allowed for flexibility of design and methods), granted by the NHS Research Ethics Committee (Appendix 7). Permissions were then granted from the local Trust Research and Development Department to be on trust premises as a recognised visitor and researcher.

Many procedural aspects of sound ethical research practice were required to be addressed for the purpose of ethical approvals. Rather than focus on many of these procedural aspects (such as the storage of data, the maintenance of confidentiality and anonymity), key elements of establishing consent and issues of position and power will be explored in this section.

3.4.9.2. Consent

Health professional consent during phases 2 and 3

The stages outlined in relation to negotiating permissions and access were integral to the consent process. It was vitally important that potential gatekeepers provided their own verbal consent for me to enter their service or to talk to their teams.

Prior to phase 1, senior clinicians (namely the ward manager and senior therapists) provided help to identify any member of staff who was likely to be directly affected by research observations. For occupational therapists and physiotherapists (and including assistants), information sessions were held in small profession-specific groups, written information was provided and the groups were given the opportunity to ask questions. Consent forms were left with individuals and were returned to the researcher individually.

For nursing staff and nursing assistants, as it was difficult for people to have time away from the ward in groups, the ward manager provided the staffing rotas during the preparatory phase and I attempted to meet with all staff, either individually or in small groups as the demands of the ward would allow. Again, written information was provided and all participants were given the opportunity to ask questions. Participant information and consent forms can be found in Appendices 8-13.

There was also a recognition that there would be many other people who may become indirect participants within the research – such as visitors to the ward, and transient members of the healthcare team, such as chaplains, pathologists, or on-call doctors. For this reason, large print notices were displayed in public areas and left on patient tables, to highlight that observational research was being undertaken on the ward. Furthermore, during every interaction or observation, I was diligent to introduce myself as a researcher, explain the purpose of the observation and ask for verbal consent from those involved to be present.

During phase 3, health professionals were approached to participate in an in-depth interview, were resent participant information, and, in part due to the length of time between phase 2 and phase 3, were asked to sign a new consent form.

Patient consent during phase 2

For patients who were approached to participate in the patient tracking phase, I approached the patient independent of any introduction from a member of the healthcare team. This was a deliberate first step to avoid issues of perceived alliances with professionals. At this first stage, the researcher provided verbal and written information, including an ‘at a glance’ written summary and read information out-loud if required. The patient was given opportunities to ask questions and left for a minimum of 24 hours to consider their involvement in this study. Although initially hesitant that this would compromise my ability to be involved in real-time acute health care decision-making, this 24-hour time period was a requirement of the University and NHS Research Ethics Committee approval. After 24-hours, I returned to the patient to judge whether the person had understood and retained the information and if they were able to give consent. For those able to give consent and willing to participate, the written consent form was completed at this stage. However, although written consent was obtained prior to any involvement, a ‘process-consent’ (Dewing, 2002) approach was also adopted with all patient participants, whereby at each point of contact, information about the purpose of the observation or interaction was revisited and permission sought to continue on that given day.

Patients who were not able to give consent

When potential cognitive impairement (either short term related to an issue such as delerium, or longer term impairment) had been identified by the healthcare team, I still approached the participant with information about the study as a first stage. This was in line with principles of the Mental Capacity Act (Department of Health, 2005) which stipulates that capacity is specific to each decision, and should be assumed to be present until assessed otherwise. Initial discussion and sharing of information enabled me to determine whether the person was able to understand and retain the information either at the end of the first interaction, or on return after 24-hours.

Out of five patients, four provided consent following this process. For one patient, she was unable to understand or recall information at the end of the first interaction, therefore the process for seeking advice from a consultee was followed (Appendix 14). In this case, the patient was still given information about the study and assent was sought, and her son acted as a consultee and advised that he thought his mother would have no objection to being involved. The outcome of this consultee advice was recorded using the consultee form (Appendix 15) and this patient was included in the study. It is important to note that, for the four patients who were able to consent, capacity to consent and ability to communicate wishes was not always obvious mainly due to frailty and hearing problems. For one patient where this was particularly notable, her daugher was present during all interactions and gave her own support of involvement in the research.

3.4.9.3. Issues of Power

At the research planning stage, I had reflected that my role as a qualified health professional and a legitimised researcher within the setting potentially introduced power dynamics within my relationships, particularly in my relationships with patients. This was particulary pertinent as I would be interacting with patients at a time of significant vulnerability during an acute hospital admission. Issues to minimise the issue of a potentially powerful research postion were given signifcant consideration during planning and ethical approval (with many of the strategies such as introductions which were independent of health professional interactions and adopting a process-consent approach outlined above).

A power issue I had not anticipated in as much depth was the issue of power created through my role as a university lecturer and the past relationships I had with some of the occupational therapists when they had previously been students. During an observation, approximately mid-way through phase 2 of fieldwork, I observed one such occupational therapist undertaking an assessment with a patient. As we walked away she shared her own reflection that ‘it’s like being a student again’. Although we briefly laughed and continued talking, this encouraged me to question whether she, and others in this position, may be experiencing pressure because of the perception that their practice was being observed by a university tutor. Whilst not being in a position to eradicate the emotional responses arising from this shared history based on student-tutor relationships, it did encourage ongoing sensitivity to this issue. It reminded me of the importance of continuing to revisit the purpose of my role and of negotiating consent so as not to capitalise on, or exploit these relationships (Goodwin et al, 2003).

Another issue of power that I have reflected upon is one that is documented in critique and commentary of ethnographic research as ‘privilege’ (Coffey, 1999). In ethnographic research, the observer is often cast as a privileged ‘other’ who has the luxury of time and resources to explore the social world, and claim representations as their own. During the course of fieldwork, I recognised the privileged position I was in to be able to afford time and cognitive resources to such in-depth observation and analysis. This was particularly felt when contrasted with the busyness of the ward and of the time and resource pressures which were being experienced by all (explained in more detail in the reporting of findings). Whilst elements of this were inescapable, I became mindful that the representation of findings should not be detached from participants, but should aim to resonate with participants in the field.

3.4.9.4. Avoiding Harm

Many of the examples of which patients to recruit, processes to gain consent, and approaches to difficult conversations or approaching ambiguous topics were driven by an overriding concern to avoid or minimise harm. Although activities within fieldwork were planned to some extent, some activities and elements were serendipitous and therefore unpredictable. In other ethnographic accounts within healthcare, it is discussed that in unpredictable situations, professional codes of conduct should be used to guide research practice (Goodwin et al, 2003) and avoidance of harm is widely cited as a founding principle of healthcare ethics (Beauchamp and Childress, 1989) and of my own code of professional conduct (RCOT, 2015).

The fact that it is often reported as ‘first, do no harm’ (McLean, 2016; General Medical Council, 2015) provides support that this ethical principle overrides others and explanatory offerings for my own decision-making, particularly in relation to selection of patients to approach for involvement, and managing the potential for illuminating challenges with decision-making. However, the extent to which this principle reflects contemporary healthcare which encourages positive risk-taking and attempts to move away from professionally-led decisions and interventions has received critique (Walton & Kerridge, 2014).

3.5. Chapter summary

This chapter began with a discussion of social constructionism and how this underpins the research. A commitment to naturalistic and qualitative research emerged, promoting the exploration of meanings, interactions, social constructions and behaviours in the context in which they occur. Principles of ethnographic and case study research were presented.

A critical, yet pragmatic overview of methods chosen and applied was discussed Because of emphasis given to observation within ethnographic research, detailed and specific consideration was given to this as a method to generate research data, focussing on research decisions such as the type of observation utilised, the level of participation adopted, and the essential activity of recording notes during episodes of observation. The chapter concludes with sections discussing qualitative validity and strategies to ensure ethically sound research.

In its entirety, the chapter (and supported by detailed appendices) presents an audit-trail of decision-making, an insight in to alternatives considered at each stage, and balanced evaluations when reaching decisions in real-world research.

CHAPTER FOUR – RESEARCH FINDINGS: DESCRIPTIONS

4.1. Introduction to research findings (chapters four to seven)

This is the first of four chapters presenting research findings. Writing an ethnographic account can take many forms including: realist ‘tell-it-like-it-is’ approaches; the creation of ‘ethno-dramas’ of possible worlds; or documenting internal dialogues and commentaries from the researcher (Brewer, 2000). Principles of what has been termed a ‘post post-modernist’ approach to ethnographic writing have been adopted which aims to adopt an authoritative voice, but acknowledging the naturally selective nature of the instances chosen and phenomenon represented (Brewer, 2000). Brewer suggests strategies such as presenting persuasive and evocative narratives and use of exemplary vignettes can enable a rational presentation and assessment of findings whilst not disguising them as infallible or absolute.

Where there is certainty about exact words and who they were spoken by (by referring to audio recordings), this is indicated clearly within the presentation of findings by use of double quotation marks and attributing the verbatim extract to an interview participant. Where the researcher was relying on her own recall and translations within fieldnotes, single quotation marks are used within the text although where possible, this is again attributed to an identified person within the field. If fieldnotes did not identify quotes or extracts as attributable to particular individuals, but instead reflected general discussions or perspectives from multiple players, this is again denoted. Where narratives are used from patient tracking, the extract has been placed within a text box. Finally, where a topic represents my own impression formed within the social context, this will be attributed as such. Table 4 illustrates how these different elements are represented within the findings chapters.

Table 4 - Examples to illustrate the presentation of findings

Example	**Explanation**
“the word rehab…they’re going to a rehab ward and there’s physio’s there” (I4)	A direct quote, supported by a transcription of an audio-recorded interview or vignette, attributed to interview participant 4.
And this issue was discussed by the base ward physiotherapist, highlighting that a patient could potentially make ‘good progress with intensive rehab but don’t feel we have that here’	Attributed to the base ward physiotherapist, although the researcher cannot be fully confident of exact wording due to issues of recall and her own translation in field-notes
…therapists on the rehabilitation ward discussed that they can experience a lack of clarity, and sometimes anger, from patients or relatives linked to unrealistic expectations of rehabilitation	Concept not attributable to one identified person within the field, but discussions with groups or multiple people reflected in fieldnotes.
Patient 5 was transferred to the base ward 2 days after his emergency admission for a suspected stroke or seizure but what was later determined to be a worsening of symptoms associated with Parkinson’s Disease	Example taken from tracking of patient five, with references within the text box to objective information taken from clinical records alongside discussions and observations with patients, family members and professionals.
It was my impression that this normally resulted in daily support for more junior medical staff, and new patients and urgent issues being reviewed in a timely way	The text represents a personal impression formed by the researcher, linked to features within the social context.

4.2. Chapter introduction

Fieldnotes from the all phases of data collection are used in this chapter to present a thick description of environments, roles and activities, all with the aim of building a detailed understanding of this context. ‘Thick description’ (Geertz 1973, cited in Lincoln & Guba, 2000) – an appropriately explained base of information about the salient features of the context - assists the inquirer and reader of research findings to make judgements about transferability and fittingness to their own areas of interest. Within ethnographic research, explanations and theory-building cannot be attempted before phenomena are defined and described (Hammersley, 1998).

This first findings chapter will therefore begin with description of the study-site, before describing the main professional roles, and an outline of a typical day. Changes to the study site between phases of data gathering will also be described in this section, illuminating salient issues affecting practice and decision-making at different points in time. This section will then conclude with a descriptive presentation of the stages involved in evaluating rehabilitation potential.

4.3. The study site

The research was situated in a large NHS Trust, providing hospital and community services (in addition to some locality based social care services), serving a large population and geographical area. At the time, hospital provision occurred across an emergency care hospital, alongside 9 other inpatient sites including general hospitals, community hospitals and smaller units. The particular focus of the study involved fieldwork within one of the general hospital sites.

4.4. The base ward

One ward was identified as the main focus for the study, hereafter referred to as the base ward. Patients were admitted to this ward (mainly from the emergency care hospital) for treatment and management of general medical issues. The hospital had other established pathways for the treatment and management of condition-specific admissions such as stroke, fractured neck of femur and cardiology conditions, therefore the most common reasons for admission to this ward included treatment for co-existing conditions and co-morbidities including falls, infections and delirium. The ward was referred to most commonly as a ‘Care of the Elderly’ ward, although was also referred to as an ‘Acute Medical’ ward and there was a recognition that it had a remit which combined both of these types of service. Although the ward accepted people over the age of 18, due to the demographics of those requiring inpatient hospital services, the majority of individuals were over 65, with a high proportion of patients over 85.

The majority of admissions to the ward originated from the emergency care hospital site. There were occasional admissions from other wards within the same site, and occasional direct admissions from out of area hospitals. The ward did not accept direct admissions from the community or from other services such as the intermediate care unit (described below).

During fieldwork, many staff shared perspectives about the current nature of the ward, particularly since the opening of the emergency care hospital. Anecdotally, staff shared reflections that the dependency, medical instability and complexity of patients had recently increased. Bed managers also acknowledged that they tended to now use this ward for people who were more medically unwell, but who needed to move on from the time-limited emergency care site.

Staff also shared the perspective about how this had influenced the purpose and function of the ward. On a couple of occasions, staff started conversations or reflections with ‘when we were a rehab ward’, with the subsequent discussion suggesting that rehabilitation was no longer a primary focus due to the dependency and complexity of patients. Staff suggested that when patients moved in to a phase more primarily focussed on rehabilitation, they would often be transferred elsewhere.

4.4.1. The physical environment of the base ward

The ward had physical space for 28 beds (with four six-bedded bays and four single cubicle rooms), although during fieldwork, was operating with a capacity of 26 beds. The beds utilised depended on the amount of male/female patients, the need for single rooms and other individual factors such as the need for visibility from the nursing station due to falls risks. A diagram of the layout of the ward (not to scale) is provided in Appendix 16 to illustrate the spatial layout of the ward. Some important features of the physical layout are described below.

There was no dedicated area on the base ward for therapy or rehabilitation activities. Patient bays, corridors, beds and bathrooms were utilised for assessment or practise of mobility, transfers, and personal care. Patients were accompanied off the ward to other environments for activities such as step or stair practice, or to carry out activities in an assessment kitchen or bathroom.

The nursing station was a central, and public area, and was staffed by the ward clerk between 8.30am-4.30pm. Many functions were performed at the nursing station, including receiving and making telephone calls, admitting ward visitors using the intercom and using desk space to complete clinical records. It was in close proximity to a treatment and medication room and to many of the patient cubicles and bays. These features contributed to it being a place of congregation with many interactions and opportunities for information exchange.

In front of the nursing station was a large whiteboard listing the name and allocated bed of every patient on the ward and also indicating individual information about issues such as mobility status, falls risk, and an Early Warning Score system (EWS) based on vital signs. This was another central and public point within the ward environment and a place which encouraged convergence and information sharing.

On the periphery of each bay was a notes trolley containing patient medical notes for those within the bay. Notes trolleys could be moved around the ward for the purpose of ward rounds or Multi-Disciplinary Team (MDT) meetings. However, most often they remained static in the position adjacent to each bay and again, provided another junction for small meetings and information sharing. Staff could often be observed standing and writing records, using the trolley as a substitute for desk and office space. Small groups would often take opportunities to converge and it would be common for relatives to attempt to discuss issues with staff at these points.

4.5. Linked services and care environments

4.5.1. The rehabilitation ward

This was a 24-bedded ward on the same general hospital site although again, bed numbers fluctuated with flexibility to increase and open beds in response to pressures. Most admissions to this ward were internal transfers from other more acute wards on this site, and most transfers were based on the premise that this ward provided a slower stream and more intensive approach to rehabilitation for older people with complex needs.

The physical environment differed to the base ward in that it had a larger number of single cubicles and some 2-bedded and 4-bedded areas. It also had a dedicated therapy area on the ward with physical rehabilitation equipment such as parallel bars, steps and pedals.

4.5.2. The bed-based intermediate care unit

This unit was in the same locality area as the general hospital, although not on the same site. The unit was jointly funded by NHS and Social Care funding, with staff provided through different funding and contractual arrangements, and premises managed by the Local Authority. The overall unit consisted of 2 areas – a downstairs area with 12 beds allocated for orthopaedic admissions and an upstairs area with 13 beds for general care of the elderly admissions.

All admissions to these beds came from one of the NHS Trust hospitals and although historically, the unit had accepted direct admissions from the community, this was no longer permitted. The unit had the explicit aim of being a 6-week assessment and rehabilitation service although staff acknowledged that this specific timescale was not always possible to achieve or enforce.

The unit had dedicated nursing cover between 7.30am and 8pm although overnight there was no qualified nursing staff onsite. Consultant geriatricians from the NHS Trust also provided medical cover for this unit although did not visit every day.

4.5.3. The reablement service

The reablement service was a short term support service, funded by Adult Social Care. The service had a stated purpose of supporting rehabilitation and convalescence following a period of illness, hospital admission or following the onset of a new disabling condition. Similar to the residential intermediate care unit, the service provided short-term support for a maximum of six weeks.

The service consisted of ‘locality leads’ in co-ordinator roles - who had responsibility to carry out initial assessments and establish and review plans and packages of support appropriate to needs – and supported by scheduling officers and a large team of support workers. There was no occupational therapy or physiotherapy personnel within this service.

Referrals could be made by any health and social care professional although in reality, the hospital social workers had the main responsibility for referring a patient who was being discharged from a hospital ward, and this was discussed mainly for pragmatic reasons in that they had access to the local authority systems. If screened to be appropriate, a short term reablement package could then be put in place quickly (normally within 24-48hours).

Professionals discussed the potential benefits of the reablement service in terms of accessing packages of home support within short time scales, alongside promoting ongoing work towards functional goals, such as returning to outdoor mobility, or becoming more confident with a new walking aid. Some frustration was expressed with the limited opportunity to communicate specific active rehabilitation goals, and also with the absence of rehabilitation professionals integrated within the team. An example of this discussed by a physiotherapist was that if specific physiotherapy input was required to review range of movement following a fracture, a separate referral to community or day-service physiotherapy would also be required.

4.6. Occupational therapy and physiotherapy staffing for the base ward and the linked rehabilitation services

The occupational therapy and physiotherapy staffing for the base ward, and in comparison to other rehabilitation services is presented in Table 5.

Table 5: Occupational Therapy and physiotherapy staffing for the base ward, rehabilitation ward, bed-based intermediate care unit and reablement service.

	Base Ward	**Rehabilitation Ward**	**Intermediate Care Unit**	**Reablement Service (Community)**
Occupational Therapy	1.0 Band 6 Access to pool of assistants Weekend cover from hospital-wide service	1.0 Band 6 0.5 Band 6 Access to pool of assistants Weekend cover from hospital-wide service	1.0 Band 6 1.0 Assistant Both staff covered both orthopaedic and elderly rehabilitation units No weekend cover	No dedicated service
Physiotherapy	1.0 Band 7 (also with service lead responsibility) Access to pool of assistants Weekend/ evening/night cover from hospital-wide service	0.6. Band 6 1.0 Band 5 1.0 Assistant Weekend/ evening/night cover from hospital-wide service	1.0Band 6 (orthopaedic unit) 1.0 Band 6 (elderly rehab unit) 1.0 Assistant covering both units No weekend on on-call cover	No dedicated service

4.7. Roles and working patterns within the base ward

4.7.1. The Consultant Role

Two dedicated ‘care of the elderly’ consultants had overall medical responsibility for the patients on the base ward with the aim of at least one consultant visiting the ward on a daily basis. Consultants did not allocate specific patients (or bed spaces) between them, but instead whichever consultant visited the ward on the identified day, would see any new patients, review issues of medical urgency, and discuss any queries or plans with the ward medical, nursing and therapy team. It was my impression that this normally resulted in daily support for more junior medical staff, and new patients and urgent issues being reviewed in a timely way. Both consultants had many other additional clinical, teaching and leadership roles across the trust.

4.7.2. Ward doctors

The base ward had four junior doctors allocated to cover all medical issues on a daily basis. In reality, with these staff also on on-call rotas for night and weekend cover, or away from their duties to attend teaching or sit exams, there were many occasions when there were less than four, sometimes when there was only one on duty. Ward doctors normally worked between 9am-5pm, with on-call staff covering at other times.

4.7.3. Nursing

Nursing care was provided by a team consisting of 14 qualified staff (Bands 5-7) and 11 healthcare assistants (Bands 2-3). 24 hour cover was organised around three main shifts – early, late and night shift – with staff also occasionally working long days, or ‘office hours’. During fieldwork, the ward had between 2-4 qualified nursing staff on duty during early shift and most often 2 qualified staff on duty for late shift and night duty, ideally supported by 4 healthcare assistants. In reality, staffing was often reduced by planned and unplanned leave, sickness, and the requirement to attend training or meetings.

Nursing staff worked in teams, covering an identified ‘side’ of the ward. Each side incorporated two of the six-bedded bays and two single-bedded cubicles. In general, I observed attempts to keep staff on these identified sides on different shifts to promote continuity of care, however, there were many occasions where this was not possible.

4.7.4. Physiotherapy

The physiotherapy team covered the base ward between 9am-5pm. There was no formal referral system and instead the physiotherapist monitored all patients within the base ward and made judgements about prioritisation. The physiotherapist discussed that a referral system had been considered, although used the example that the team did not want to be in a position where they found out key information, such as a patient having stairs, at a later stage. Therefore, the team operated a ‘blanket referral system’, meaning they screened all patients, and then made judgements about appropriateness for, and level of, involvement.

The ward physiotherapist discussed the model of working and general rules that informed workload management and prioritisation. These general rules included the aim to see all new patients on their first working day within the ward, and aiming for every patient to be seen every weekday by a member of the team (which included assistants). However, the team recognised that this was often not realistic or appropriate, and on a daily basis, priorities were reviewed and negotiated, normally based on information from the morning handover and from continuous information sharing during the day.

Outside of the normal working hours described above, on-call respiratory physiotherapy cover was available during evenings, nights and weekends, and 9am-5pm cover for a standard physiotherapy service was also available at weekends through a rota of existing staff. Reasons for being seen by physiotherapy at weekends included assessment for issues which could facilitate discharge (for example mobility and stair assessments), to continue to promote carryover of progress (for example to practice standing or transfers), or to assist in non-urgent management of respiratory issues (such as supporting ward teams to ensure that patients at risk of respiratory complications were sitting out of bed during periods within the weekend days).

Physiotherapists did have departmental office space in another area of the hospital and also utilised a physiotherapy treatment area a short walk from the base ward. The allocated physiotherapist also spent time on many other wards providing supervision and cover for other staff. Despite this, they could often be found on the base ward and discussed largely basing the working day within this location.

In their own words, one physiotherapist described this role as:

> “working with them [patients], and goal setting with the patients to just try and get maximum function and independence really. And…with…from a physio point of view then that’s, you know, transfers, mobility, things like that” (I1, line 32).

4.7.5. Occupational therapy

The allocated occupational therapist for the base ward provided services between 9am-5pm, Monday-Friday. The occupational therapist operated a referral system from ward staff whereby ward staff used a referral book to highlight when a patient required occupational therapy and to provide basic information about the patient’s situation. A box on the daily handover sheet would indicate if the patient had been referred to occupational therapy. The occupational therapist was also observed to operate outside of this system and to initiate the referral themselves if they felt this was warranted either from the morning MDT handover, or from information received through informal ward interactions.

No evening or overnight occupational therapy provision was provided. The wider occupational therapy team operated a rota-based weekend service from existing staff, with weekend referrals initiated from either ward based occupational therapists on a Friday for urgent involvement over the weekend, or from ward-based staff referring newly admitted patients. Priority for weekend involvement focussed on those patients who had the potential to be discharged during the weekend, or early the following week if the assessment and planning took place over the weekend.

The occupational therapist was also normally present on the ward on a daily basis, alongside having a departmental base in another area of the hospital site. They were observed to work more regularly from the departmental base than the physiotherapist, and this was acknowledged by the occupational therapists themselves, with the difference in the way of working attributed to the increased need for visits to patient's homes, the use of facilities within this departmental base (such as the assessment kitchen and bathroom areas) and the need for a quieter environment to liaise with family, carers and a range of services through telephone contact.

Again, in the words of one of the occupational therapists who participated in this study, insight in to the role is provided below:

> "a lot of our role does centre around discharge facilitation…completing initial assessments to see how they were managing in terms of mobility and such like. How they were managing with ADLs, possibly doing further assessments…kitchen assessments, washing and dressing assessments etc. And em…my…and then considering whether they need support at home, any equipment, adaptations, that sort of thing". (I5, line 6)

4.8. A typical day

In the context of this ward, activities were observed as happening at different times of day and night. However, for the purpose of this section, activities that were observed occurring regularly throughout Monday-Friday daily routines are summarised.

Early morning activities included a shift handover between the nursing staff on night duty and the nursing staff beginning an early shift. This would take place at approximately 7.45am, before night staff finished their shift at 8am. Following this, breakfast was provided to all patients, some patients were assisted with personal care and toileting, and observations and medication administration commenced (although this could also commence later depending on staffing, the need to meet hygiene and toileting needs and the urgency of any other issues).

Doctors, occupational therapy, and physiotherapy staff normally began arriving between 8.30am and 9am and if there in advance of the 9am handover, could often be seen at the nursing station, often reviewing records. The MDT handover took place at 9am on Monday-Friday and staff were largely diligent about observing the timetable for this activity. This would normally be completed by 9.30am.

Between 9.30am-12pm, I observed a contradiction of activity. From one perspective, staff presented as being very busy with a multitude of activities happening simultaneously and with significant speed. An example of this could be nursing staff performing quickly and simultaneously the administration of medications, responding to patient-call alarms, holding conversations with patients and professionals, assisting with observations or other procedures and responding to telephone queries from relatives about how a patient had been overnight. Ward doctors and therapy staff also discussed that the time before lunch was the most effective time to make progress with direct patient contact: discussing that this time would not be interrupted by visitors, and the completion of assessments and investigations at this time could often facilitate afternoon discharges. Consultants often attended the ward during this time to lead medical ward rounds, although this attendance was less predictable with the ward round often taking place without the consultant, and attendance later in the day used to support and review issues with the ward doctor and wider team. Rehabilitative interventions could also be observed during this time, such as patients engaging in walking practice with a member of the physiotherapy team, or being assisted with transfers out of bed by nursing staff and therapists.

From another perspective, the contradiction was seen when focussing observations on any one particular patient, where the activity involving each individual could be limited and fragmented. Within this time an individual could be typically assisted with personal care, be visited by the ward doctor during the ward round, visited by the physiotherapist, and provided with a mid-morning hot drink. However, these interactions characteristically tended to be short (perhaps no longer than 15 minutes and potentially as short as a few seconds) and interspersed with much longer periods with no interaction. As many patients were frail and still in the acute stages of a hospital admission, many could be observed sleeping or sitting quietly during this time. Some were able to engage in self-directed activities such as reading a newspaper. Later in this period (between 11am-12pm), nursing staff were scheduled for timed breaks and once essential routine care activity was completed (for example personal care, medications, observations and procedures), breaks would commence, again contributing to a quieter time for individual patients.

The period between 12pm-1pm was identified as a ‘protected meal time’, a practice which is used to enable patients to eat meals without interruptions from hospital staff and to free up staff to assist patients with feeding and eating. It was my perception that a commitment to protected mealtimes was to be observed in the main and therapy and medical staff often used this period to have their own break.

The period between 1pm-2pm was observed to be an extension of the earlier period, where assessments and routine care activities resumed. A nursing shift handover would also take place around this time between staff working an early shift, and the late shift commencing at 1.45pm. At 2pm, the first of two 1-hour visiting periods began, although staff often commented that visitors would often attempt to arrive earlier and a queue could often be observed at the door from approximately 1.30pm. During the visiting period, many staff could still be seen to be present on the ward although alongside the routine care activities, communication with relatives also became significant, and professionals who emphasised their role in understanding home and social situations – namely occupational therapy and social work – were perhaps more often seen at this time. Staff also used this time for indirect patient activities such as record keeping and telephone calls, discussing their awareness of the importance of visiting time and the desire to keep professional interruptions to a minimum.

Other ward and hospital activities were also scheduled during afternoons, such as the weekly MDT meeting, the three times weekly Length of Stay meetings, and staff supervision and development activities. After 3pm, and after the end of the first visiting period, some assessments and care activities resumed although this period after 3pm did not have the same sense of busyness or activity level, with professionals discussing that the highest priority activities often took place earlier in the working day to provide the maximum time to resolve issues or facilitate a transfer. This sense of reduced activity continued until late afternoon and evening time with the protected evening meal time happening between 5pm-6pm, and the second visiting period between 6.30pm-7.30pm. This then led in to the nursing handover and the commencement of a quieter evening routine.

4.9. Description of key activities observed during fieldwork

4.9.1. Multi-disciplinary team (MDT) daily handover

The MDT handover took place on the base ward at approximately 9am every week-day morning. It lasted approximately 30 minutes and was led by a qualified nurse. In addition to the nurse(s) who took the lead role for this meeting, it was attended by core members of the MDT including ward-based medical, occupational therapy and physiotherapy staff. Alternative occupational therapy and physiotherapy staff sometimes attended if the identified therapist was not on duty and there were sometimes occasions where there was no representation from identified disciplines. One of two identified social work staff were also often in attendance, although notably less frequently than other staff. On less frequent occasions, one of the allocated consultants or health professional students also attended.

The handover meeting was held in a corner of the ward; the environment was discussed by the ward manager as being chosen to promote privacy and confidential discussion, although still within view of the nursing station and the white-board. Although chosen for reasons of privacy, this was not a closed area and was within very close proximity to some patient areas.

The meeting was structured around a daily printed handover sheet (see Appendix 17 for an example) and each professional normally collected a copy of this from the nursing station. Nursing staff on night shift were responsible for generating this new handover sheet on a daily basis, populating with the most up to date information about every patient on the ward. The handover sheet layout utilised a structure of ‘Situation, Background, Assessment and Recommendation’ (SBAR) – a recognised and structured technique to promote information exchange between individuals or within teams (NHS Institute for Innovation and Improvement, 2010). On some occasions, the SBAR framework was used as a verbal structure to discuss patients during the meeting, however, more often, each patient was discussed using a more narrative approach. No formal records were taken although individual professionals would make their own notes either on the printed handover sheet or in the case of the ward doctors and the physiotherapist, by using a ‘jobs’ book.

4.9.2. Nursing handover

These meetings represented an information exchange between nursing shifts. Again, the printed handover sheet was used to exchange key information, and these meetings tended to focus on medical and nursing tasks. Examples included the need to get a Midstream Specimen of Urine test (MSU), or to ask medical team to review Intravenous Antibiotics (IVABs). Although heavily focussed on medical issues, this handover also included the sharing of information about wider issues such as contact with family and the need for wider referrals. Information from this handover often informed information then updated on the printed sheet or information shared at the 9am handover meeting.

4.9.3. Weekly multi-disciplinary team (MDT) meetings

Weekly MDT meetings were more formal in nature than the daily handover meeting. Led by one of the consultants, the MDT meetings were attended again by all core members of the ward-based team (namely nursing, occupational therapy, physiotherapy and social work), and lasted between 1.5-2.5 hours. On occasion, additional professionals attended this meeting, for example a link nurse from the psychiatry of old age service, or a ‘nurse assessor’ (a nurse with responsibility for continuing healthcare assessments).

The consultant, supported by the ward doctor, recorded entries in the medical notes. Nursing and therapy staff tended to make informal notes on their own printed handover sheet or within log books. The regular attendance by the consultant, the use of a closed room removed from the patient area (a shared patient and staff ‘day room’), and more formalised entries in medical notes all contributed to the impression my perception of this as a more formal meeting, in comparison to daily or shift handovers.

Each patient case would be presented and discussed in more depth than the daily handover and plans formulated accordingly. Although the structure of each case varied, commonly the consultant would summarise important background information pertaining to the admission, with the detail varying depending on an implicit judgement of how well the team knew the patient and how much information they needed to review. This summary would then lead to a presentation of current status, including issues such as skin integrity, continence, nutrition and pain, which mainly involved a dialogue between the consultant and the nurse. As the physiotherapist was involved in almost all cases, they would also contribute to this review and add an update on current mobility. Occupational therapy and social work professionals would contribute to cases where they were involved.

Plans made within the base ward MDT presented as being focussed on assessment and stabilisation of acute issues -for example trial without a catheter (TWOC) or carry out a Mini Mental State Examination (MMSE; a standardised screening tool to assess for the presence of cognitive impairment (Folstein, Folstein & McHugh, 1975)) to monitor acute delirium - and plans which could facilitate transfer or discharge - for example, referral to a nurse assessor; or to list for the intermediate care unit or rehabilitation ward. However, it would also be common for plans to be much less explicit, with the use of statements such as ‘needs more time’, ‘more physio’, or ‘home later in the week’.

Although some of these examples did link to patient goals, goal-setting was experienced as a more implicit part of the process, with specificity about desired outcomes and timescales often not clearly stated. Timescales for plans or goals were often left unconfirmed and the use of question marks within the medical entries from MDT meetings was a common occurrence (for example ‘? home at the end of the week’ or ‘? rehab bed’). Patients and family members were not present at weekly MDT meetings.

4.9.4. Length of stay meetings

These meetings were hospital-wide reporting meetings which took place three times weekly. They were held outside of the immediate clinical areas in various rooms in the base hospital building. The attendance and format at the three meetings I attended varied greatly although core membership presented as being a directorate manager who chaired the meeting, alongside a representative from physiotherapy, occupational therapy and a service involved in facilitating discharge. The varied format experienced presented as being linked to changes in personnel, particularly to the allocated chair of the meeting.

In advance of the meeting, a list was circulated to these core members which included details of every patient within the hospital with a ward length of stay (LOS) over 14 days. Members then had identified responsibility for gathering information from specific wards and reporting back to the meeting. The nature of the updates regularly included examples such as ‘ongoing rehabilitation’, ‘awaiting nurse assessor’ or ‘awaiting a package of care’.

Professionals discussed a feeling that issues could potentially be misrepresented at these meetings with the potential for blame to be apportioned. They discussed the desire to avoid examples which could be attributed to delays with their own profession (for example ‘awaiting stair assessment’, or ‘awaiting home visit’). Language used to describe patient choices within the meeting was also of interest with statements such as ‘refused a bed on the rehab ward’, or ‘failed the home visit’ being noted during these meetings.

4.10. Description of changes to the study site between phase 1 and phase 3

Although phase 3 involved interviews with health professionals and therefore did not involve any direct work-based observations or interactions, it is important to note that the researcher became aware of some significant service changes that had happened during the period between phase 1/2 and phase 3. These changes are important to the context of the research and will therefore be summarised in this section although, as I did not carry out fieldwork observations during this phase, my understanding of these changes is solely based on the perspective of professionals.

During phase 2, staff received information that the intermediate care unit would be closing (this information was made available to staff in June with a proposed closure date of September of the same year). When the researcher returned in April of the following year for the further period of data collection, the intermediate care unit had closed, and rehabilitation beds had been provided in a different location. The new site had previously been a nursing care environment and the rationale for the re-provision included the building being more accessible and fit for purpose. There was no longer a split between orthopaedic rehabilitation and general elderly rehabilitation, with instead a reduced number of beds provided for all general rehabilitation. Some therapy and care staff had moved across from the intermediate care unit although staffing was reduced due to the reduced number of beds.

Another significant change between phase 2 and phase 3 was a change in function of the previously identified rehabilitation ward. During phase 3 interviews, this was discussed by professionals as no longer being an identified rehabilitation ward, but instead labelled as a ‘discharge ward’. It was discussed by professionals that if all active interventions had been completed and a patient was, for example, only waiting for a care package, they could then be transferred to this ward.

Professionals discussed that overall bed numbers within the hospital remained broadly the same although medical treatment and active rehabilitation was now all provided within the base ward, and on other wards with similar purposes (for example another elderly medical ward, the orthopaedic ward, respiratory ward among others) until the patient was deemed to be at a level safe for discharge. Professionals discussed that a philosophy of co-located medical and rehabilitation treatment underpinned this, with the rationale of reducing unnecessary internal transfers which had the potential to delay interventions or complicate communication. Physiotherapists discussed that the idea was that they would no longer need to provide as much active therapy for patients on the new discharge ward (and therefore able to concentrate staff resources in fewer geographical locations) although discussed becoming quickly aware that patient needs were potentially not being met in terms of maintaining current levels of function and mobility (for example a person's ability to mobilise could deteriorate whilst they were waiting for the care package). They discussed that there were examples where this had subsequently affected wider discharge planning (such as equipment and care package requirements) and resulted in further delays.

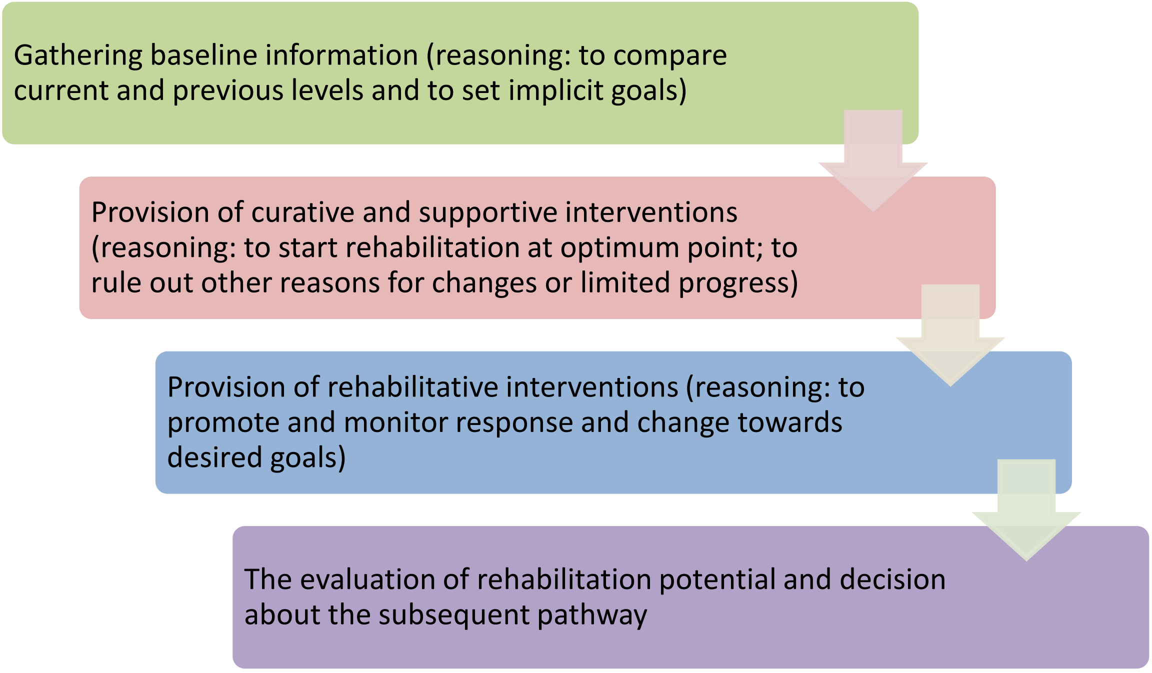
One further change discussed was the introduction of a 'Discharge to Assess' multi-disciplinary team, operating in to the acute wards over the hospital site. This was only briefly mentioned by professionals and therefore understanding of this initiative is limited. However, professionals discussed that at an early stage of an acute admission, patients were now being referred to this team who would carry out a generalised assessment of safety to be discharged home. Following this, profession-specific assessments including full physiotherapy and occupational therapy assessments, would then be carried out in the community. Enhancements to the community rehabilitation provision were also under discussion.

There were likely to be many other organisational and service-level changes in the period between phase 2 and phase 3 of fieldwork. However, the above changes presented as being important to note and are referred to in later interpretations and discussion.

4.11. Description of how professionals evaluated rehabilitation potential

The section below provides a description of decision-making in relation to rehabilitation potential, based on data gathered from general fieldwork, specific observations during patient tracking and discussions with a range of health professionals. Decisions or judgements about a patient’s rehabilitation potential could happen at any time and therefore the process was not necessarily a linear one, with discreet or separate stages. However, there were commonalities observed and discussed in the section below. Figure 5 represents a simplified version of this process, with Figure 6 providing explanatory detail.

Figure 5: Overview of reasoning process to evaluate rehabilitation potential



4.11.1. Stage: Gathering baseline information and comparing current and previous levels

The understanding of baseline information was discussed by health professionals as one of the first steps in evaluating rehabilitation potential. 'Baseline' was a term used across all professionals in the setting and interpreted to relate to information about a patient's previous level of health, disability, function and social support. Through the review of clinical records, this information gathering was understood to commence during the initial assessment – mainly the initial nursing assessment at the emergency care hospital – and then continued through a series of slightly different, although overlapping, discipline-specific assessments, sometimes at the emergency care hospital or sometimes initiated on arrival at the base ward. This baseline information was often revisited formally (for example, through questions asked during physiotherapy or occupational therapy initial assessments), or more informally (for example, through talking to relatives or through discussion with professionals who may have known the patient from a previous admission).

Information about particular aspects relating to pre-admission function were included in both physiotherapy and occupational therapy assessment tools (for example, pre-admission mobility and transfer status were documented in particular places within the discipline-specific assessment documents). Nursing and medical staff also took opportunities to gather information although, with the exception of the initial nursing assessment completed on admission, any further information was documented in an un-structured way within general entries in the medical notes. The responsibility to gather this information was not always clear in the patient cases observed.

An element which presented as influencing this stage of the process was if the person was already known to the team. For example, during a discussion with the base ward physiotherapist about patients being listed for weekend physiotherapy, the physiotherapist highlighted that ‘she is likely to be here for a while…know her from a previous admission and she can normally walk approximately 15 metres with a zimmer frame’.

4.11.2. Stage: Provision of curative and supportive interventions to resolve or manage issues which may impact on ability to make functional gains

The team discussed the impact that acute medical issues had on reaching judgements about rehabilitation potential and that attempts were therefore made to resolve and treat particular issues which could potentially be resolved. The team inferred that this in turn informed and improved the judgement about rehabilitation potential. For example, the consultant summarised a patient in an MDT meeting on the base ward by indicating ‘he is now eating and drinking much better and on a more normal diet and fluids…this can make a big difference to rehabilitation’.

The physiotherapist on the base ward reflected on a past case during one discussion, suggesting that ‘if I’d seen him in writing as to when he first got here…I would have thought he’s going to take a week or two…but it all depends on…getting rid of the delirium’. And the same physiotherapist, when discussing Patient 2, mentioned ‘…some of the pressure issues she’s got on her legs, so that’s going to obviously affect any mobility progression. But that’s now under treatment which is a medical issue’.

Although curative, supportive and rehabilitative interventions were observed being delivered and facilitated simultaneously, it was implied that the impact of rehabilitative interventions, and therefore meaningful judgements about rehabilitation potential, could not be evaluated until the team had worked towards potential resolution of acute problems. This was not only because acute medical issues which changed, improved or deteriorated, could rapidly change the functional presentation of a patient; but also related to the fact that acute medical issues often meant that patients were not well enough to engage in the type of rehabilitation activities (for example mobility, transfer or stair practice) which may help to facilitate the desired functional improvements.

An example was discussed within an MDT meeting on the base ward where the occupational therapist asked the team if they needed to prepare the family that the patient was unlikely to make functional improvements and therefore a return home was unlikely. At this point the consultant stated ‘she has been unwell…needs more time. [We’ll] review in a week and see what kind of progress we’re making.

4.11.3. Stage: Provision of rehabilitative interventions and monitoring of progress

Following comprehensive information gathering and the provision of curative and supportive treatments, the importance of engagement in a rehabilitation process in order to make meaningful judgements about the likelihood of making functional gains was observed. In relation to Patient 2, the physiotherapist on the base ward discussed ‘it’s early days yet and we’ll see what happens…so until I see that progress, that initial this is where we are…I can then make that decision (about the patient’s rehabilitation potential)’.

In the case of Patient 2, during the first MDT meeting following her transfer from the base ward to the rehabilitation ward, the consultant verbally discussed that she was ‘not sure what her rehab potential is…give her 2 weeks and review’. She also added that the team would be guided by ‘OT and physio’ during this time. This was reinforced by a written record of the meeting which stated ‘more time for rehab – review 2/52’.

4.11.4. Stage: The evaluation of rehabilitation potential and decision about the subsequent pathway

Although not a linear process, once the team had worked to stabilise acute medical issues, and evaluated the likelihood of further functional gains, this then subsequently informed a more confident evaluation of likely progress and decisions about where a person would go next or which (if any) services they would be referred to. This evaluation of likely progress and the decision about the pathway are presented as one stage because they were difficult to separate – something that will be discussed in later sections.

Decisions about the pathway from the base ward observed during the period of fieldwork included: patients remaining on the base ward for a period of rehabilitation; patients transferred to the rehabilitation ward; patients transferred to the intermediate care unit; patients transferred to a specialist unit for cognitive assessment and rehabilitation; patients discharged home with referral to another service who could provide rehabilitation (most frequently the reablement service although occasionally other services such as referral to a day hospital or community physiotherapy service); or patients discharged home or to another care environment (for example 24 hour nursing care) with no further rehabilitation. At this stage, the consideration of access to finite rehabilitation resources – such as availability of beds or waiting lists for specific services – was observed as being influential in the reasoning of practitioners. More detail about all of these stages are illustrated visually in Figure 6.

Figure 6: Detailed reasoning process to evaluate rehabilitation potential and reach decisions about the rehabilitation pathway (continued overleaf)

<table>
<tr><td colspan="3">Stage 1: Gathering Baseline information and comparing current and previous levels</td></tr>
<tr><td>Professional assessments of current medical, physical and functional status
- Primary medical condition
- Secondary issues (e.g. pain, delirium, pressure)
- Mobility
- Functional level and care needs (e.g. self-care, toileting and continence)
- Cognitive ability
- Mood</td><td>COMPARED TO</td><td>Information gathering about previous level
- Comorbidities
- Previous mobility
- Previous functional level and care needs (informal and formal)
- Previous cognitive ability
- Home environment (physical and social)

(NB if previously known to services, use this information)</td></tr>
<tr><td colspan="3">Evaluate the differences between current and previous and implicit goal setting (which differences can be improved?)

Early judgement about rehabilitation potential – informing decisions such as need for professional involvement (e.g. referral to OT), need for weekend therapy etc</td></tr>
<tr><td>Stage 2: Provision of curative and supportive treatment and care to resolve or manage issues which may impact on ability to make functional gains</td><td>Alongside or followed by</td><td>Stage 3: Provision of rehabilitative interventions and monitoring of progress</td></tr>
<tr><td>For example to treat infections, mal-nutrition, constipation, manage pain

Evaluate curative/supportive interventions and review as required</td><td>And

Or</td><td>For example mobility and/or stair practice, introduction of new aids or equipment, education regarding self-management of hygiene, toileting.

Evaluate rehabilitative interventions– are they bringing about desired change (is the person making gains)?

If not, evaluate reasons – medical reasons, motivation, carryover, environment, resources?</td></tr>
</table>

Stage 4: The evaluation of rehabilitation potential and decision about the subsequent pathway

More detailed judgement about rehabilitation potential – continues to inform decisions such as need for professional involvement (e.g. referral to OT), need for weekend therapy, identification of appropriate bed/ward, and referrals to ongoing services (e.g. reablement team, community physiotherapy etc). These elements then inform the pathway decision which is a combination of consideration of rehabilitation needs/potential and the availability of rehabilitation resources/beds.

Pathway decisions observed during fieldwork:

A Rehabilitation on base ward:	**B** **Rehabilitation on other inpatient hospital ward:**	**C** **Rehabilitation within intermediate care unit:**	**D** **Rehabilitation at home (with reablement and/or supported by other community services)**	**E** **Transfer (home or to 24 hour care) with no rehabilitation services**	**F** **No Decision about rehabilitation**
Reasons for decision observed/ discussed: *Has rehab goals* *Professional judgement suggests desired changes will be quick* *Occasionally if patient vocal about not wanting a move*	Reasons for decision observed/ discussed: *Has rehab goals* *Transferring with assistance of 2 people (or more)* *Seen as 'complex' (e.g. complex medical, social, behavioural)*	Reasons for decision observed/ discussed: *Has rehab goals* *Transferring with assistance of 1* *Less nursing/medical needs than 'B'*	Reasons for decision observed/ discussed: *Has rehab goals* *Current needs and risks judged to be manageable with maximum home care package*	Reasons for decision observed/ discussed: *No rehab goals* *Judged that the person/family can manage their own rehab progression* *Any achievement of goals perceived as unlikely to influence outcome*	Reasons for decision observed/ discussed: *Medical needs are prioritised – not appropriate to reach judgement about ongoing care or transfers* *Palliative Care on base ward*

4.12. Description of the use of criteria for referral to rehabilitation services

There was no written criteria for referral to the rehabilitation ward observed to be in use. Decisions about transfers to this ward were observed to be made drawing on tacit knowledge and reasoning processes from different members of the MDT at different times. It was discussed that the decision to list for the rehabilitation ward was ultimately the decision of the consultant, although they themselves acknowledged that they drew on information and judgements from other members of the team, mainly the physiotherapist.

For the intermediate care unit, no formal, written criteria for this service was observed in use during fieldwork, although professionals working within the base ward, rehabilitation ward and within the intermediate care unit itself did frequently verbally refer to an understanding of eligibility criteria – mainly the need for patients to live within the locality area, to be medically stable, and to be able to mobilise or transfer with one person. Professionals demonstrated an understanding of this criteria through their own stories and ways of knowing, rather than referring to written or explicit statements.

Written criteria for eligibility for the reablement service was available (see Figure 7). Again, there were no occasions where I observed professionals directly referring to this, and indeed one social worker (despite the social work role essentially acting as a gatekeeper for this particular service) discussed that there was no criteria for this service. Instead of making direct reference to the criteria, professionals referred to examples and stories where they had found out the criteria by default.

Figure 7: Written criteria for reablement service

Customers must:

- Be 18 or over
- Be residents of **** (locality area) – NB those of ‘no fixed abode’ will be included if deemed eligible through the assessment process
- Be eligible for support in line with current **** (locality are) eligibility criteria for Fair Access to Care Services
- Be medically stable
- Be safe to be at home between visits
- Be in agreement to a referral being made
- Have the potential for improvement, benefiting from a reablement programme
- Have the motivation to participate in the programme and agree goals

Although services had been reconfigured by the time of phase 3, discussion of how criteria can influence decisions arose during interviews with health professionals. One professional reflected on an example of implicit criteria; for example because the new rehabilitation facility did not have standing hoists, it had become implicitly understood that this represented a form of exclusion criteria in that people who needed this equipment could not be managed in this environment.

The presence of rehabilitation potential itself did form part of explicit and implicit criteria for rehabilitation pathways. For example, the requirement to have the potential for improvement was stated within the written criteria for the reablement service. And, in relation to the new rehabilitation facility which opened following the closure of the intermediate care unit, the base ward physiotherapist reflected that “one of the things I always say to people when they send them to (new rehab facility) is ‘they’ve got to have rehab potential’ (laughs)”.

4.13. Chapter Summary

This chapter describes the location and purpose of the ‘base ward’, situated within a large NHS system covering a large geographical area. The descriptions of wider services linked to this ward have also been presented in order to understand the most commonly utilised services for ongoing rehabilitation pathways. The features of the base ward and the linked services, including the roles of different professionals and the array of professional activities, act as a physical, social, cultural and temporal backdrop for decision-making.

The working patterns of the different professionals are of interest and will be referred to in subsequent chapters. Through the tracking of patient cases, and through time spent in numerous interactions and activities with professionals, the process of evaluating rehabilitation potential has been described. Although this has been presented as a series of stages, in reality this was not necessarily happening in a linear way.

Professionals described that the provision of rehabilitative interventions was an important stage in evaluating rehabilitation potential, in order to assess carryover and progress. This is interesting to hold in mind in light of themes developed within future sections which illuminate the many challenges to providing rehabilitative interventions experienced by professionals on the base ward.

CHAPTER FIVE – RESEARCH FINDINGS: SOCIAL CONSTRUCTION AND MEANING-MAKING OF ‘REHABILITATION’ AND ‘REHABILITATION POTENTIAL’

5.1. Chapter introduction

This chapter will explore how concepts and processes integral to the research objectives were being social constructed. Again drawing on extensive fieldnotes from observations and interactions, alongside interview transcripts and extracts from clinical records, I will present instances and examples where key terms were used, discussed and represented.

This section will develop definitional elements – outlining how the concepts of rehabilitation and rehabilitation potential were constructed within the setting. Whilst Hammersley (1998) suggests that it is unlikely that the main claims of ethnographic accounts will be definitional, definitions will form an important part of the substructure to build explanations and shape meanings.

It was an initial objective of the research to explore the meaning of the term ‘rehabilitation potential’ within this context although it quickly became obvious that exploration of the term ‘rehabilitation’ almost preceded understanding relating to rehabilitation potential (and was reflected in revised research objectives). Therefore the chapter will begin by discussing the social construction of rehabilitation, before discussing the concept, and influences on the evaluation, of rehabilitation potential.

An overview of how initial codes and examples from data led to the development of themes and sub-themes is provided in Figures 8 and 9 (NB social construction and meaning-making of rehabilitation and rehabilitation potential began as two themes and were later combined).

Figure 8: Coding and theme development – social construction and meaning-making of ‘Rehabilitation’

Early Coding:

Began as one merged theme of ‘Meanings’ and all data was reviewed using the code ‘Meanings’. All data then reviewed again using code of ‘Rehabilitation Meaning’.

Rehabilitation meaning:

- A process to bring about improvements
    - “To get stronger”
- A process to improve mobility…but changed to a process to achieve safety
- Associated with physiotherapy
- A place
    - Happening in specific beds
    - But should be a phase of care
    - A place to go when others don’t know what to do
    - A way of moving within a system
- Something interchangeable with other terms (e.g. Re-ablement)
- Something not living up to an ideal
    - Should be multidisciplinary
    - Should be focussed on patient goals
    - Should focus on more than mobility
    - Should have more time
    - Should be intensive
    - Should have an enabling environment
- A process to improve quality of life
- An overwhelming idea for older people
- Misunderstood by others
    - Physio’s rehab people
    - ‘all-singing’, ‘all-dancing’
- Contrasting objectives

Examples from the data:

Rehabilitation:

A process to bring about improvements:

I4: “building or regaining skills”

P5 (Fieldnotes p199) “to get stronger”

Improving Mobility:

I1: it always does seem to go down to right, transfers, mobility

Physiotherapy:

Patient tracking examples – physiotherapy involved earlier and more frequently.

Focussed on Safety (linked to organisational objectives):

I3: “And now it’s become safe only”

A place:

Fieldnotes p141; I1 ‘waiting for rehab’

Fieldnotes p19; p42; ‘listed for rehab’

Not ideal/not happening:

I1; I2: versions of ‘proper rehab’

Needing time:

I5: “the way I look at rehabilitation is having time to work with something…somebody…”

Final themes and Sub-themes:

Theme: Social Construction and Meaning Making of Rehabiliation (combined with social-construction and meaning of rehabilitation potential on next page)

Sub-themes:

Meaning of Rehabilitation

- Rehabilitation as a process to bring about improvements
- Rehabilitation as a process to bring about physical improvements
- Rehabilitation as physiotherapy
- Rehabilitation as a place
- Versions of rehabilitation – ideal versus reality
- Meaningful rehabilitation and time
- The objectives of rehabilitation
    - Patient-centred objectives and goal setting
    - Organisational objectives

Figure 9: Coding and theme development – social construction and meaning-making of 'Rehabilitation Potential'

Early Coding:

Began as one merged theme of 'Meanings' and all data was reviewed using the code 'Meanings'. All data then reviewed again using code of 'Rehabilitation potential meaning':

- Not sure! (difficulty defining/explaining)
    - A guess?
    - Subjective
    - Influenced by many factors (became separate theme)
- Different professional perspectives:
    - Potential to get back to baseline/back to 'normal'
    - Potential to get back to baseline mobility
    - Potential to achieve goals
    - Potential to be safer
    - Potential to influence discharge outcome
- Limited when known to have had rehabilitation previously
- Identified as having rehabilitation potential when others don't know what to do
    - The judgement can be controversial
- Linked to engagement with a rehabilitation process
- Therapists want people to have rehabilitation potential
- Potential for what?
- Inextricably linked to a judgement about the pathway

Examples from the data:

Rehabilitation Potential :

Difficult to define - I2: "one of those holy-grail phrases we use in the NHS"

Potential to get back to baseline - Fieldnotes p13; p91; p99 'the ability to improve back to baseline'

Potential to improve mobility - Fieldnotes p33; p46; p99; 'whether someone's current mobility is different to their baseline mobility'

Potential to achieve goals - I1: "It should always be goal-specific"

Potential to be safer: I1: "the rehab potential would be to get to a safe point"

Potential to influence discharge outcome: Fieldnotes p32 "Already in sheltered plus so what else would ward ** do?"

Limited potential when previously known to have had rehabilitation:

When others don't know what to do: Fieldnotes p64 "get sent people with "Rehabilitation Potential" when other wards don't know what to do with them"

Therapists want people to have potential - I1: "I think your natural instinct within the physio profession to always maximise somebody's mobility"

Open to challenge – I4: "people come and you're kind of like well, what is it that we're actually doing here".

A best guess - I2: you're sort of like, picking a point in the distance and saying this is where we want to be

Potential for what? – Fieldnotes p228 – links with mental capacity. what

Final themes and Sub-themes:

Theme: Social construction and meaning making of rehabilitation potential (combined with social construction and meaning-making of rehabilitation)

Sub-themes:

Meaning of Rehabilitation potential

- An ambiguous concept…potential for what?
- Potential to get back to baseline
- Potential to get back to baseline mobility
- Synonymous with a transfer of care
- Potential to influence discharge outcome
- Controversial and open to challenge
- Influences on reasoning

5.2. The meaning of rehabilitation

5.2.1. Rehabilitation as a process to bring about improvements

In simple terms, the word rehabilitation could be seen as being attributed to a process which facilitated improvements from the current state. When asked directly within interviews to express the meaning of rehabilitation in their own words, a number of responses reflected a process which aims to bring about improvements:

> “For me rehabilitation is somebody getting back something that they’ve lost. So if they’ve had an ability before…em…then…my aim, if I was rehabbing them, would be to try and get them back to that point to where they were before” (I2, Line 74)

> “Working towards getting them back to that level of function that they were previously at. Em…obviously sometimes it may not be…we may not be able to get them back to that baseline so that functional level would drop down. So therefore, you’re rehabilitating back to their maximum potential” (I3, Line 8)

5.2.2. Rehabilitation as a process to bring about physical improvements

Despite these overview statements indicating rehabilitation as a process which aims to bring about different types of functional improvements, observational and interview data suggested a more narrow focus on rehabilitation; conceptualised as a process which aimed to improve physical abilities, and more specifically, mobility. During a ward round on the base ward, one of the consultants was observed concluding a patient interaction with a statement that the team would ‘get the physio’s to get you moving’. Also, from review of records during patient tracking, ‘ongoing physio’ was frequently cited as a plan or recommendation from ward rounds and MDT meetings, and ‘ongoing mobility work’ or ‘decreased mobility from baseline’ were cited as reasons for listing for a bed on the rehabilitation ward.

In relation to one patient, the occupational therapist asked the team ‘does she need rehab for mobility?’, and concerning another patient, a discussion in an MDT meeting raised whether someone needed the reablement team ‘for mobility practice’. And although rehabilitation goals were often very general or implicit on the base ward, it was common for the MDT meeting to include planning around mobility issues, such as ‘aiming to progress to mobility with a stick’, or ‘needs stair assessment’. This was also reflected by Patient 5 when asked why he was going to a rehabilitation ward, he responded ‘to get stronger’.

It was also recognised by one professional that this was perhaps part of how the meaning of rehabilitation was more broadly interpreted in society:

> [people think of rehabilitation as a] ‘getting soldiers to walk again kind of place’. (I4, Line 61).

Professionals were aware of this dominant focus on mobility when discussing this issue within interviews:

> “so, we need to have goals…but within the team, and that’s the whole team, it always does seem to go down to right, transfers, mobility, that seems to be where everyone hones in on” (I1, Line 82).

They also offered reflections and explanations for this focus, particularly linked to what rehabilitation means in the context of acute hospital care:

> “Because I think mobility is quite key in terms of all of the other activities of daily living…for the majority of people, [mobility] is their number one priority of being able to manage something themselves…I think it really is the cornerstone of everything else going on” (I2, Line 95).
>
> “All the other areas of rehab have dwindled away…there isn’t the time to look in to other areas of ADLs that would need a bit more time, that we could have assistance to support patients in those roles. And then, mobility is really the last thing that we’re left with perhaps” (I5, Line 39)

Although this focus on mobility and physical abilities presented as being a dominant interpretation of the focus of rehabilitation, this was not to the total exclusion of other areas. An example was noted during tracking of Patient 3, where the documented notes from an MDT meeting on the base ward identified the management of ‘own stoma bags and catheter’ as part of the plan. Another example included a patient with Motor Neurone Disease whose upper limb function was recognised as affecting washing and dressing and toileting abilities.

Another such example of wider functional goals being part of a rehabilitative process was illustrated when a patient on the base ward was reviewed by a liaison psychiatry service for a review of mood. The liaison psychiatry service recommended that staff on the ward promote ‘1:1 activities and engagement with staff’. However, after this, some of the staff discussed that this would be ‘nice to do, but not realistic’. This echoed the sentiment shared within I5 that when time is pressured, other areas of rehabilitation have ‘dwindled away’.

5.2.3. Rehabilitation as physiotherapy

Referring again to quotes illustrated above, it was common for handovers and MDT discussions to identify ‘ongoing physio’ as a general statement about the status of the patient and their admission, or as a reason for transfer to the rehabilitation ward. During patient tracking, it was identified from records that most patients received physiotherapy from the outset of their admission to work towards improvements in their mobility. Occupational therapy provision generally commenced later and was less frequent (summarised in Table 6).

Table 6: Summary of occupational therapy and physiotherapy involvement during patient tracking (continued overleaf)

Patient	PT Initial assessment	OT Initial assessment	PT contact on base ward	OT contact on base ward	PT contact on Rehab ward	OT contact on Rehab ward
1	At emergency hospital – on day of admission	On base ward – on day 6	Transferred on day 2, assessment on day 3 10 contacts documented between day 3 and day 24 (with a focus on mobility and respiratory issues)	No further contact on base ward	After transfer on day 24 (Friday), seen on day 27 (Monday) Multiple contacts with a focus on mobility	After transfer on day 24, seen on day 44
2	At emergency hospital – on day of admission	Not assessed	Transferred on day 2 and seen for PT assessment on same day. 2 further contacts documented between day 2 and day 9	N/A	After transfer on day 9 (Friday), seen on day 13 (Tuesday) with a further 5 contacts documented until day 29	N/A
3	On base ward (as transferred from out of area hospital). Assessed on day 4 (Monday after transfer on previous Friday)	On base ward (as transferred from out of area hospital). Assessed on day 5 (Tuesday after transfer on previous Friday)	Following initial contact on day 4, 3 further contacts focussing on mobility documented until day 21	No further contact	N/A (Remained on base ward)	N/A (Remained on base ward)
4	Unclear from records	Unclear from records	Transferred to base ward on day 6 and seen for PT assessment on day 7	Assessed by OT on base ward on day 13	N/A (Discharged home from base ward)	N/A (Discharged home from

						base ward)
5	At emergency hospital on day 2	At emergency hospital on day 2	Transferred to base ward on day 2. Assessed by PT on day 3 Further 13 entries documented between day 3 and day 25	Assessed by OT on day 17. Further 1 entry documented between day 17 and day 25	Transferred to base ward on day 25 (Friday). Seen by PT on day 28 (Monday). Further 7 entries documented between day 25 and day 36	Seen by OT on day 32. Further 3 entries documented between day 32 and 36.

Although the data set is small and does not capture contextual information or influences (such as therapy staffing levels, waiting lists, dependency levels of patients), this information does highlight general trends that physiotherapy tended to be involved earlier and more often than occupational therapy within this context.

Looking more closely at the information provided in Table 6, from the five patients who became the focus of patient tracking, three patients moved from the base ward to the rehabilitation ward (Patients 1,2, and 5) and were therefore perhaps in a more obvious rehabilitative phase of care. For the three patients who were transferred to the rehabilitation ward during their stay, all three continued to receive physiotherapy quickly after the transfer and there was documentation which supported work towards mobility goals during this period. In contrast, only two of the three patients received occupational therapy on the rehabilitation ward and this commenced between 7 and 20 days following transfer. It is important to note however that both of these patients had been seen by occupational therapy at an earlier stage.

In the case of Patient 2, this person did not see an occupational therapist at any point during their admission. Interestingly there were discussions in MDT meetings, supported by entries in the medical records which suggested that occupational therapy would play a part in the rehabilitation of this patient - for example, medical notes documented a plan of ‘More time with OT/PT’, and the consultant discussed in an MDT meeting that the team were ‘not sure of her rehab potential…to be guided by OT and PT’.

Physiotherapists presented as being aware that other members of the MDT closely associated rehabilitation with physiotherapy interventions. During interviews, one physiotherapy participant suggested:

> “I think if you looked at the wider team and you said ‘what’s rehab?’ to somebody other than the physio’s, the OTs etc., those therapists involved in rehab…I think they would give a very simplistic idea of what rehab is…oh yeah you’ll walk with the physio and then you’ll be better” (I3, Line 107)

And an occupational therapy participant reflected that “the physios did more rehab” (I2, Line 27) and linked this to the level of physiotherapy staffing.

Participants also reflected that patients, families and perhaps wider society held similar views:

> “The word rehab…they’re going to a rehab ward and there’s physio’s there” (I4, Line 331)
>
> “People see physio, they think ‘physio – rehab’, that’s…I think that’s everybody in the population in general. It usually starts with the guy running on the football pitch with the sponge, oh that’s what physio does…physio rehab people… the vast majority of people’s perception of what rehab is is mobility work, so who mobilises patient’s?” (I3, Line 620)

This way of interpreting the meaning of rehabilitation was not just present in the consciousness of professionals and patients, but predictably filtered in to other elements of the hospital system and decision-making. During interviews in phase 3, professional’s described that some wards in the hospital were beginning to implement a new initiative around identifying each patient on specific wards as having ‘green days’ or ‘red days’ with a green day utilised if the person was receiving active interventions from any member of the healthcare team, and a red day utilised if the person had completed active interventions and was now waiting for, or ready for discharge services. An interesting insight shared during an individual interview suggested that if a patient was receiving active physiotherapy, they were identified as having a 'green day', although if they were receiving active occupational therapy they were labelled as a 'red day' and aligned this to the interpretation that occupational therapy was seen by the team as a discharge planning service rather than a provider of active rehabilitation.

Reflecting this, an extract from an interview with an occupational therapy participant highlighted that when they did try to focus on aspects of rehabilitation wider than mobility, this was not readily appreciated by others:

> "I've recently had someone that…was physio safe and I was kind of pushing for them to have further time on the ward because they couldn't manage bed transfers and initially it was kind of like, well, can we not just get a carer" (I4, Line 87)

A final interesting insight here was that if something was labelled as a provider of rehabilitation but did not include physiotherapy, professionals struggled to conceptualise this as rehabilitation:

> "We've got the community rehab team as well…it's completely new…basically…when the [intermediate care unit] closed down the teams were made up of support workers who worked…so they've all got a really good background of rehab. The problem that we've got with that team at the moment is that it doesn't have any kind of physio that's…em…connected to the team. So at the moment we're not using them that much from the hospital." (I1, Line 397)

5.2.4. Rehabilitation as a place

Many different discussions alluded to rehabilitation as a particular place, including when someone was 'waiting for rehab', or 'listed [or coming off the list] for rehab'. Furthermore, when staff on the base ward conceptualised rehabilitation as a place, they also clearly conceptualised that the place they had in mind was not their own ward. The expressions of ‘waiting for rehab’ or ‘listed for rehab’ suggested that it was the next place of care, and hence the move away from the base ward, which would result in the provision of rehabilitation. And this issue was discussed by the base ward physiotherapist, highlighting that a patient could potentially make ‘good progress with intensive rehab but don’t feel we have that here’. Most often, the statements about waiting for a bed referred to a move to the rehabilitation ward based on site, or a move to the intermediate care unit.

The medical team on the base ward alluded to transferring people for rehabilitation who were more medically stable with one of the ward doctors suggesting that when he was ‘only doing smaller things…[it] means they can manage her on [the rehabilitation ward]’. This links to rehabilitation being conceptualised as the phase of care which follows medical treatment and stabilisation, and in this case characterised by a movement in place.

Developing this idea, the change of location was linked to freeing up a specialist bed, with rehabilitation being perceived as being provided in a more generalist location. Examples included an extract from an interview with one of the occupational therapists:

> “Now that I’m on ward (respiratory), we talk about patients needing further rehab and they are referred to a care of the elderly ward… because our ward is specifically medical for respiratory patients, they need the beds for those patients and then patients would go to a care of the elderly ward which we also refer to as rehab wards. And…it’s no different…there isn’t any increased support there” (I5, Line 68).

The final part of this extract suggested little difference in the resources and support provided by different wards, despite a movement of place often being conceptualised as a move to more intensive rehabilitation. A discussion with the physiotherapist on the base ward echoed this, discussing that a move to the intermediate care unit is often suggested as a move for intensive rehabilitation, but in reality it may not be that different. Linked to this, a member of staff from the intermediate care unit suggested there were elements where this unit actually had less resource for rehabilitation, highlighting in particular that there was no weekend therapy input.

Despite honest acknowledgements that wards were often not dissimilar in terms of staffing and resources, there was still a strong narrative implied on the base ward that the rehabilitation ward and the intermediate care unit would have increased resources to provide more intensive rehabilitation (in terms of time, staff and facilities), and hence why the concept of rehabilitation was intrinsically linked to these locations. When discussing Patient 5, the occupational therapist on the base ward reflected that ‘they’ve [the rehabilitation ward] got more time’. When reflecting on the reasons for internal transfers within the hospital, another occupational therapist during an interview suggested that staff hold views such as ‘we’ll send them to [the rehabilitation ward] because they’ll have more time to sort them out’.

Linked to this, I observed that when a patient was listed, and waiting, for a bed on a rehabilitation ward, he or she potentially became a lower priority for rehabilitative interventions on the base ward. An example of this was noted with Patient 5 who, from the first documented entry which indicated listing for the rehabilitation ward, waited 4 days to be transferred to the rehabilitation ward. However, in this time (despite earlier entries in his clinical record focussing on improving consistency with mobility and transfers), the base ward physiotherapist discussed ‘handing him over to the assistant’, implying that this was linked to the fact that he would not be discharged imminently and therefore became lower priority. This was echoed by the base ward occupational therapist who became involved with Patient 5 at a point when the ward team were discussing discharging him directly home, although she subsequently ‘prioritised him out’ when he was listed for the rehabilitation ward.

5.2.5. Versions of rehabilitation - the ideal versus the reality

Many staff discussed features of their ideal version of rehabilitation. During the early stages of the study, the base ward physiotherapist discussed the idea that rehabilitation should be a phase of care and ideally involve a 24-hour approach with all staff working towards rehab goals. At various points within fieldwork the same physiotherapist indicated an incongruity between an ideal state of rehabilitation and what could be provided on the base ward with statements such as ‘we’re doing the bare minimum’ and ‘we don’t have that [intensive rehabilitation] here’.

Interview extracts implied incongruity between what therapists thought rehabilitation should be and what it actually was in the context of their practice:

> “I think we all want this ideal text book thing…you know, goal-led, get the carers, get the family members, get the patient, do it all together. But it’s not always as easy as that. Unfortunately.” (I1, Line 258)
>
> “The way I look at rehabilitation is having time to work with something…somebody…on some meaningful activity….It’s working with them daily, having daily input with that person, practicing tasks, so that they can…possibly become independent or improve in their independence in that area that we’re looking at. But that relies on having the time to do that.” (I5, Line 22)

Words like ‘should’ and ‘meant to’ were frequently used when reflecting on ideas and ideals of rehabilitation, being suggestive of a difference between what professionals would like rehabilitation to be, and what it was in reality. The use of the word ‘proper’ added another interesting insight, which again was suggestive of discrepancies between ideal and reality but with language that suggested that alternative versions of rehabilitation may be in some way improper:

> “So then I ended up getting shouted at because people hadn’t got the moving and handling plans done and hadn’t had their site visits done because I’d been doing proper rehab” (I2, Line 39).
>
> I1: “It’s a multi-disciplinary…and goal-led…that’s what I tend to think…if we’re looking at proper rehabilitation” (I1, Line 54).

The idea of rehabilitation as a phase of care was highlighted within an interview extract, although again suggested that this was an aspiration rather than an established way of working:

> “[Rehabilitation] could be a place...or a philosophy of…what do I do in this rehab? I’ve started to mark out patients who are getting towards that rehab part of their stay and em…and then getting the healthcare’s etc. involved. So everything that patient does is then focussed towards function and rehabilitation…that’s what I want to create on the ward and it takes that whole emphasis about…oh physio, they’re rehab, they’re mobility. It’s not…it’s everybody’s job to get involved with that” (I3, Line 78).

There was an awareness that this discrepancy between ideals of rehabilitation, and what rehabilitation actually constituted, particularly on the rehabilitation ward and intermediate care unit, could perhaps lead to challenges in managing patient and family expectations. During fieldwork observations, professionals on the base ward acknowledged that the rehabilitation ward can get ‘sold’ to people as a place for intensive rehabilitation, and therapists on the rehabilitation ward discussed that they can experience a lack of clarity, and sometimes anger, from patients or relatives linked to unrealistic expectations of rehabilitation. This was echoed within interviews:

> “I sometimes feel it’s kind of sold to people like it’s rehab and people…you know people who aren’t in the profession or kind of work with elderly people have big expectations of what a rehab hospital or ward would be like. And in reality, it’s not kind of all singing, all dancing you know” (I4, Line 58).
>
> “Because if you say to a patient that you’re going to rehab, the family, they really cling on to that and they’re expecting some intense rehabilitation” (I5, Line 89).

5.2.6. Meaningful rehabilitation and time

Time is mentioned in many areas of the research findings; for example the time needed when evaluating rehabilitation potential, the pressures on time for certain rehabilitation activities and the narrative of ‘more time’ as a recommendation when situations were unclear or emerging. It is important to note here that professionals did associate the allocation of time as being linked to the quality of a rehabilitation process. One professional, when asked to describe what they meant by the concept of rehabilitation highlighted the importance of time as their first reflection:

> “the way I look at rehabilitation is having time to work with something…somebody…” (I5, Line 22).

5.2.7. The objectives of rehabilitation

5.2.7.1. Patient-centred objectives and goal-setting

An explicit goal-setting process was not observed on the base ward. During, daily handovers, discussions were centred around professionally-led actions rather than patient-centred goals. Goals were a little more obvious during weekly MDT meetings on the base ward – with examples such as ‘aiming to progress from mobilising with a 4-wheeled walker to mobile with a stick’. However, from researcher observations, this applied in only some cases within MDT meeting discussions, and again the discussion tended to focus on professionally-led actions.

Goals were evident within some examples of clinical records, although difficult to find at times. Physiotherapy and occupational therapy entries sometimes included information about goals (for example ‘aim to increase exercise tolerance and aim for independence with mobility [physiotherapy entry for Patient 1]; ‘aim to progress to independence’ [physiotherapy entry for Patient 1); ‘transfer practice’ [occupational therapy entry for Patient 5]). This was sometimes contained in profession-specific assessment documentation, and sometimes mentioned in general continuation records. In some examples of clinical records, there was no explicit documentation of goals.

I also did not observe explicit discussion with patients about their goals, with instead goals discussed implicitly with patients (‘we’ll get the physio’s to get you moving’; ‘we’ll try you with a frame without wheels’). Discussion with family members about goals were also not explicitly observed. I was aware that some patients had planning meetings although the timing and reasons were not always fully clear and the attendance of different members of the MDT was recognised by the team as unpredictable. I attended a planning meeting for Patient 5 which was attended by family members, the social worker and the occupational therapist (but without the patient who had been invited but decided not to go) and again discussions focussed on professionally-led actions such as the referral to reablement, the requirements of the care package and the organisation of a key-safe to enable carer access to the home.

Finally, in relation to goals, a physiotherapist shared the reflection that when they got to the point of thinking about goals, patients tended to leave the base ward to go elsewhere.

5.2.7.2. The organisational objective of rehabilitation

To conclude this section which examines the conceptualisation of rehabilitation, over the course of the data collection period (more specifically during the course of the 12 month period between commencing observations and completing in-depth interviews), professionals expressed a shift in the way the organisation was communicating the purpose and desired objectives of rehabilitation.

During phase 1 and 2 of fieldwork, I understood one of the primary objectives of rehabilitation as promoting functional improvement, most often an improvement linked to mobility or physical abilities. The expression ‘back to baseline’, most often in relation to baseline mobility, formed part of discussions and observations several times every day, in relation to most patients. The purpose of rehabilitative interventions therefore presented as aiming for improvements towards the person’s previous baseline.

It became very quickly apparent during phase 3 (interviews with occupational therapists and physiotherapists), that the narrative had changed in relation to this.

> “So…we would be looking at…obviously…em…their level of mobility prior to coming in is a factor, so that we had an idea of what their b…we’re not supposed to use the word baseline now” (I1, Line 23).
>
> “We’re not allowed to say we’re getting people back to baseline” (I2, Line 79).
>
> “I was going to mention baseline function…this is now a bit of a nasty word within the trust…baseline” (I3, Line 304).

Through trying to understand this issue further, professionals described the reason for this as the Trust encouraging a movement away from working towards achieving a return to baseline function, towards encouraging a focus on achieving safety for discharge, which may or may not be achieved through the achievement of functional gains. Again, this was expressed strongly in a number of interview extracts:

> “So it used to be, like we said earlier, baseline or better. Then it became baseline only. And now it’s become safe only rather than…so…an example would be someone independently walks with a stick when they came in, they are now independent with a zimmer frame, and at that point they are safe to go home” (I3, Line 135).
>
> “What they’re saying is that we…it’s all about…em…us not looking at getting people back to their baseline. It’s about people being discharged at a level that is safe” (I1, Line 40)

Professionals did express a general understanding in relation to this, with an awareness that this was being driven by organisational objectives to reduce length of stay and facilitate patient flow, both of which enabled the Trust to ensure the most acutely unwell patients would be able to access the services they needed. However, although able to recognise the rationale, professionals expressed concerns and counter-arguments in relation to this:

> “Fair enough, we can all see that. But the problem that we have is that if they’re not back at their baseline…em…we don’t really have a huge about of community services to ensure that people then can progress in the community” (I1, Line 42).
>
> “The problem that I have with that is that I sort of feel that we’re failing patients because….patients aren’t getting rehabbed back to baseline…in terms of mobility and things. That then has a huge impact on their other functional activities of daily living. And if there’s nobody picking up that baton in the community, and pushing forward to try and get them back to where they were before, then they’re

> stuck on that point and we've missed that window of opportunity and, 2 months time they get readmitted again and are we doing the same thing again. They're becoming more infirm and more dependent on other people" (I2, Line 80)

5.3. The meaning of rehabilitation potential

5.3.1. An ambiguous concept…potential for what?

When directly asked to explain the concept of rehabilitation potential in their own words during interviews, a number of the interview participants began by recognising the ambiguity and complexity of the term, almost to explain their own lack of clarity or potential subjectivity:

> "Em…well…it's a really broad term isn't it…It's quite a difficult thing…you can't put it down in one sentence" (I1, Line 148).
>
> "I think it's one of those holy-grail phrases that we use in the NHS" (I2, Line 190)
>
> "It's kind of one of those words that kind of get banded about and people use it, and there's no definitive reason as to why someone has, or someone hasn't" (I3, Line 117).

Alongside the above extracts which illustrate the difficulty in articulating what rehabilitation potential was, it was also apparent during fieldwork and interviews the term rehabilitation potential was often used globally and without specificity. Expressions such as 'what's his rehab potential?', or '? rehab potential?' were regularly part of team discussions or statements noted in clinical records.

Extracts from interviews suggested an awareness that it would be helpful to be specific in relation to which areas a person had capacity to improve within, although reflected that this is perhaps not always the case:

> "When we're looking at rehab potential it should always be goal-specific. But I don't know whether it always is" (I1, Line 245).

> "We probably don't do it [explain rehabilitation potential] enough, explicitly enough in the notes" (I2, Line 346).

Linked to this, in the absence of specificity, it was highlighted that perhaps professionals reverted to assumptions about rehabilitation potential, or the default way of understanding rehabilitation potential in this context:

> "It could be something that the OT's working with but it would just be termed 'rehab'. And I think…as I've mentioned on a handover if we see that, we just assume it means they're not back to their baseline mobility (laughs)" (I5, Line 158).

A social worker drew a comparison between evaluations of rehabilitation potential and evaluations of mental capacity with both terms being used as 'umbrella…catch all' terms. The social worker continued to discuss that when professionals indicate that someone does not have mental capacity…they need to be saying 'capacity for what?', and similarly instead of just saying someone does or does not have rehabilitation potential, professionals should instead be asking the question 'potential for what?'.

5.3.2. Potential to 'get back to baseline'

One of the physiotherapists linked their understanding of rehabilitation potential to a hypothetical patient, with that patient having 'the ability to improve back to a point of baseline or beyond, [with] baseline being where they were prior to coming in to the hospital'. Wording was echoed by other physiotherapists when describing this concept, with one suggesting 'it is about a judgement about getting as close to baseline as possible' and the other considering whether '[the patient has] the potential to get back to that baseline'.

Occupational therapists used similar descriptions with one occupational therapist indicating that the judgement about rehabilitation potential linked to whether a patient ‘still has a little bit more further input to reach their new baseline’, with another discussing that they consider ‘what they’re achieving now and where they were before…and what’s the likelihood of them getting any better’.

The meanings constructed by occupational therapy and physiotherapy were of particular interest in this study, although meanings discussed by other professionals within the environment were also significant and contributed to the wider social construction of concepts. A doctor on the base ward simply described rehabilitation potential as ‘the potential to get back to baseline’, and the consultant (in relation to patient 2) discussed that ‘she is quite a way off baseline…mainly indicated by the variance in her mobility’.

The later phase 3 interviews occurred at a time when the organisation was attempting to encourage a change in the narrative in relation to thinking about baseline. Despite this, when asked to describe rehabilitation potential in their own words, the interview extract below illustrates that the approach to conceptualising rehabilitation potential as the potential to get back to baseline continued to be significant:

> “I suppose it’s whether we think that they have the ability to improve on the state that they are in at that point of time. So, it might not be getting back to their baseline (laughs)…which we’re not supposed to be saying anymore…but actually to have an improvement in their physical and mental status so that they can em…we can see an improvement” (I1, Line 167)

5.3.4. Potential to get back to baseline mobility

Perhaps unsurprisingly, linked to significance of physical improvement, which emerged through conceptualisations of rehabilitation, this also emerged in relation to the ways in which professionals considered rehabilitation potential. When discussing influences on rehabilitation potential one of the physiotherapists discussed considering what ‘might affect potential for either muscle strength or power being built [and] whether their co-morbidity may be around exercise tolerance’.

Notably, although again unsurprising in the context of the dominant discourse amongst the professionals, was that occupational therapists also attributed similar meanings and examples to their own explanations of rehabilitation potential. After discussing their ideas of the concept of rehabilitation potential, the first example given by one occupational therapist was to suggest that ‘if a patient’s mobility is rather poor…we still have the potential to improve…to a more stable mobility level’. The same occupational therapist did go on to recognise other functional aspects, although this came after their descriptions about working towards improvements in mobility status and they then concluded the discussion by saying that ‘if there is any further rehab potential, then that can be looked in to in the community and the physiotherapists can follow up’ suggesting rehabilitation potential links to the potential to make physical gains and is therefore addressed by physiotherapy.

5.3.4. Synonymous with a judgement about transfer of care

A judgment about the rehabilitation potential of a patient on the base ward was often intrinsically linked to a judgement about appropriateness for a transfer to a less acute rehabilitation bed. However, it almost became impossible to distinguish these elements from each other and the judgement about whether someone had capacity to make gains through rehabilitation became reframed with the adjunct of the judgement about the appropriateness for the transfer or movement within a service.

A member of the hospital to home team – a team with a remit to support discharge planning and care transitions - discussed that their team could assess rehabilitation potential and used this particular term. However, on further discussion, this assessment involved gathering information about medical stability and level of current dependency on medical and nursing interventions, in turn using this information to inform a judgement about the appropriateness of an internal transfer to a less acute (rehabilitation) bed.

Also, during an interview, one participant response suggested blurred lines between the judgement about rehabilitation potential and the judgement about the appropriateness of a transfer:

> "There was a patient who got sent up to one ward and then brought back again because their rehab potential…I would say that the therapists were probably right there but they got over-ruled by the medical team" (I3, Line 581).

One of the critical challenges suggested during fieldwork observations was that the evaluation of rehabilitation potential could potentially be used as a strategy to promote movement within the system. This was observed during an informal observation on the base ward when nursing staff were discussing how to free up a bed for a medically unwell patient who needed to be transferred to this ward from elsewhere in the hospital. The discussion highlighted one patient to transfer to the rehabilitation ward although they discussed that they thought the primary aim was a 'social sort out'. A member of staff subsequently discussed that '[the rehabilitation ward] can do that, we used to do that when we were a rehab ward'.

Movement from one ward to another was linked closely to the length of stay figures for each ward; particularly pertinent as length of stay for each patient who had been on a ward for longer than 14 days was discussed and reported to organisational management.

The below extracts were expressed during interviews although were expressed in a third person style – indicating that professionals were aware that this may occur although did not express this in relation to their own practice:

> "Sometimes I think it was said, well, if it was going to be quite a complex discharge if there was a lot of problems, it seemed they'll be like they need more time so we'll send them to rehab when there wasn't really a rehab need. They

> just wanted…rid…that sounds awful…or they kind of wanted them moved elsewhere or the problem” (I4, Line 221).
>
> “[it would be said by others] “we don’t really know what to do with this patient…there’s a lot of complexities…we’ll send them to [the rehabilitation ward] because they’ll have more time to sort them out” (I2, Line 21).

Whilst recognising that a positive evaluation of rehabilitation potential could influence a transfer to a rehabilitation environment and therefore whether a person was afforded more time within the hospital environment, the reverse of this was also observed in that a negative or low evaluation of rehabilitation potential could equate to decisions not to pursue options for a patient which involved further inpatient or bed-based management.

Interestingly, once in a rehabilitation environment, the evaluation of rehabilitation potential was still linked to movement within the system although in a critically different way. That is to say, in a rehabilitation environment, a positive evaluation of rehabilitation potential was equated to a desire for the person not to move, and linked to a lack of confidence in community services to continue to develop the identified potential. Reflecting on experiences from the rehabilitation ward:

> “Well generally if somebody has rehab potential, I would usually be trying to fight to keep them where they are at, to keep them continuing on that pathway. Because, as I said, the services aren’t available once they leave hospital” (I2, Line 482).

Finally in relation to this, rehabilitation potential in some instances almost became a criterion for the internal transfer, although the extract below also suggests the critical challenge that this presents in terms of ambiguity and subjectivity:

> “One of the things I always say to people when they send them to (new rehab facility) is ‘they’ve got to have rehab potential’ (laughs). So it’s probably em…one of those things, those outcomes or one of those features that people have to have that people find it hard to find it hard to say, well, have they or haven’t they got rehab potential” (I3, Line 416).

5.3.5. Rehabilitation potential as potential to influence discharge outcome

During a base ward MDT meeting, a physiotherapist asked ‘even if [the patient] improves, do we think it will change where he ends up going?’, and this provided an insight that rehabilitation potential was not only being considered in relation to likelihood of making physical or functional improvements, but also the likelihood of influencing discharge outcome. Similarly, and again in an MDT meeting, an occupational therapist queried whether the team were listing a patient for the rehabilitation ward, although it was raised that the patient was already in an extra-care sheltered scheme and ‘what else would [the rehabilitation ward] do?’.

This perspective that rehabilitation potential equated to a potential to influence discharge outcome was perhaps most notably illuminated by an agreed approach to referring to occupational therapy where (with a few exceptions, mainly related to moving and handling risk assessments), the occupational therapy team did not accept referrals for people who already resided in residential or nursing care. Through discussion, they directly linked this to judgements that any intervention would not result in an influence on discharge destination.

During interview responses, professionals suggested an awareness of the presence of a link between rehabilitation potential and an evaluation of whether any functional gains had the potential to subsequently influence discharge outcome.

> “But I think because of…pressure to get people moved out of hospital, it’s kind of…ok, well why should we continue to try and get this person to walk if they can go to nursing care and they can look after them. So I think rehab potential does differ in that respect” (I3, Line 202)

However responses also suggested professional tensions and discomfort with this:

> “Especially if someone is always in residential or nursing care. If they come in and they were previously mobile and then…now they’re transferring with 2, it seems like they’re kind of quick to say well there’s people at home who will be

> able to manage their mobility with 2 people. But to me, if it was me, I would think well, why are they not entitled to have some therapy input to try and improve their mobility further. Just because they are already in a residential care setting…I don't really agree with that…personally" (I4, Line 103).

5.3.6. Rehabilitation potential – controversial and open to challenge

A subtheme of this section, summarising many of the issues outlined above, was that the concept of rehabilitation potential was witnessed sometimes to be controversial and open to challenge. Observations during fieldwork highlighted that professionals perceived that some wards or services might 'bounce patients back' if there was a difference in the evaluation of rehabilitation potential, or that judgements would be questioned. Indeed this was witnessed during an observation on the rehabilitation ward when, on a couple of occasions very soon after a patient transfer from the base ward, the team were observed to ask 'is [the patient] rehab-able?', and reflected that 'the physios [on the base ward] think he has rehab potential'.

Those evaluating rehabilitation potential and recommending a patient for further rehabilitation services demonstrated awareness that receiving services would be likely to question this evaluation and also that managers or other professionals may question this evaluation if this increased the length of stay in the hospital system. The below interview extract also suggests that when on the receiving end, they also judge such evaluations themselves.

> "And one of the other physio's this morning just said to me 'why did you say she was good for the [new rehab facility]…she's just laid in bed all of the time and she won't get out'…and then you're thinking in your own mind, 'ahhh…should I have said she was for [new rehab facility] and am I going to send her and…she's actually got no rehab potential'" (I1, Line 429).

The subtle differences in how different players, at different times, conceptualised rehab potential, in the main simply presented as an interesting observation although one that remained relatively unseen. The vignette summarised below involves a patient who was not part of the patient tracking (therefore their notes were not accessed and no idiosyncratic details were used), although I became aware and involved in many discussions due to my routine attendance at handovers, meetings and general ward activities.

After multiple transfers within the hospital system, compounded by an in-hospital fall which led to a fractured neck of femur, this patient was receiving care and treatment on the base ward. After returning from a period of leave, the physiotherapist shared insights that the ward staff may not see improvements because the patient was still using a full body hoist, although the physiotherapist felt he was less windswept in his posture and his standing with the standing hoist was also improved. It became obvious that a judgement about this patient's rehabilitation potential was important, and the physiotherapist shared that this patient could make improvements although did not know whether these improvements would affect his discharge outcome giving the example that irrespective of improvements, he may require long term nursing care.

During subsequent morning handovers and MDT meetings, the team – although with the main protagonists being the nursing staff and the physiotherapist – formulated a plan to continue with rehabilitation on the base ward (mainly deciding this because of the history of multiple transfers between wards and aiming to minimise further transfers if this could be avoided) in conjunction with referring to a 'Nurse Assessment' team who would assess for the need for 24-hour nursing care against agreed criteria. Both nursing and physiotherapy staff agreed that this would enable a further period of care and rehabilitation (whilst waiting for the referral to be allocated and the assessment to be undertaken), although still make progress with discharge planning, aligned to the goals of the organisation to optimise the length of hospital stay.

Over subsequent days, the physiotherapist expressed further reflections on this case, reflecting the belief that further improvements could occur and these improvements, such as improved or less dependent transfers, could significantly affect quality of life. The physiotherapist frequently used the expression 'the clock is ticking', communicating some personal pressure that quick improvements were desirable in order to justify reasoning. The physiotherapist also shared personal frustrations that this patient could potentially benefit from more intensive therapy although this was at odds with how the organisation wanted physiotherapists to prioritise patients, with the suggestion that priority should be given to those who could be discharged quickly. An awareness of the tension between physiotherapy and nursing staff was also communicated indicating that the nursing team 'see a file [medical notes] this thick and sees that he has been the same [full body hoist] for weeks. But that doesn't tell the story…he hasn't been here for the same reasons and he has had multiple things going on'.

Six days after the referral, the 'Nurse Assessment' took place which was highlighted as quicker than the ward team would normally expect (the team discussed two weeks being 'an average' expected time between referral to assessment). The outcome of this assessment was that the patient did not meet the criteria for NHS funded nursing care. The assessment also resulted in an opportunity for the patient's wife to highlight that she would like him to return home and the detail of the discussion involved her highlighting that she did not want him to sleep downstairs and would like him to manage the transfers on and off the stair lift in situ. A reflection of the researcher at this point was that she was also conceptualising his rehabilitation potential as the potential to make gains in function and mobility towards his previous baseline.

The patient's case was discussed during the next weekly MDT meeting and nursing staff and the physiotherapist were observed presenting information about the case. The physiotherapist emphasised the history of the admission, the multiple issues treated during the admission, the fact that they were only now achieving stability with issues such as nutrition and continence, and that in physiotherapy, improvements had been noted in posture, weight-bearing and range of movement. This information was summarised by stating that it was the physiotherapy opinion that this patient had not 'had a fair crack of the whip' and acknowledged later that it was a 'big thing' when the Consultant agreed.

The case was summarised in the MDT meeting by the ward doctor who indicated that 'physio feel is improving therefore list for ward ** [the rehabilitation ward]'. This was reiterated during the morning MDT handover meeting the next day where the ward Doctor again emphasised that 'physio thinks he has potential'. The team presented as placing value on the physiotherapy opinion, although in this case, the pressure on the physio to evidence and justify this reasoning was also significant, perhaps most notably through the frequent reference to the 'clock ticking'.

Following the transfer of the patient to the rehabilitation ward, the Ward Sister asked 'is he rehabable?' and one of the physiotherapists on the ward discussed that her first impressions were that he may have 'limited rehab potential' and she was left 'wondering what he has come here for'. The physiotherapist on the base ward also acknowledged that despite the patient's wife wanting him to be able to transfer on and off the stair lift, 'this may not be realistic'.

Alongside the differences noted between how different professionals subjectively conceptualise rehabilitation potential – differences in this case between physiotherapy and nursing - this example also illustrates many of the themes developed in this section – most notably the construction of rehabilitation as a process which improves mobility and strength, the meaning of rehabilitation potential as the potential to improve mobility back towards a baseline level, and the controversial nature of evaluating rehabilitation potential which can be open to challenge.

5.4. Evaluations about rehabilitation potential – influences on reasoning

5.4.1. Clinical and individual factors

5.4.1.1. Co-morbidities

Information relating to a patient’s previous health and current health presented as being an important influence on the reasoning of therapists. When discussing influences on their evaluation of rehabilitation potential, one of the physiotherapists discussed considering ‘whether co-morbidity may be around exercise tolerance such as some lung diseases…[and thinking about] frailty.’ This physiotherapist went on to add ‘it’s looking at the baseline, what has got them to that baseline or if that is just their norm for a long time and whether they’re likely to get back to that taking in to mind factors such as co-morbidities and cognition’.

The consideration of co-morbidities as factors which may predict whether someone may get back to, or beyond, their pre-admission functional level, was also obvious within the wider team. One ward doctor during a weekly MDT meeting acknowledged that one patient ‘has a long history of problems…not too significant individually but when added up might suggest limited progress’. And a therapist at the intermediate care unit suggested that ‘people with multiple conditions tend to have lower potential’.

During interviews, professionals highlighted current and previous medical and health conditions as a significant influencing factor in their professional reasoning, suggesting this information assisted them to understand whether someone was likely to improve; whether changes were likely to be chronic and enduring in nature; or indeed whether a person was likely to deteriorate. And in essence, they suggested this was integral to judgements about rehabilitation potential:

> “Always considering what their norm is before they came in to hospital, and what they’ve been through in the hospital, you know if it’s a surgery or other illness, what medication they’re taking, what is expected from the doctors as well, does somebody have a prognosis, are they a palliative patient…because like I say, if I know that patient is palliative or whatever, I know I can expect less of a rehab potential you know” (I5, Line 164).

One participant went on to offer insight that information about health, medical conditions and co-morbidities is particularly influential at an early stage of professional reasoning:

> “Because if you put a timeline on it, at initial offset you might say that co-morbidities and cognition and medical problems may be the things that are focussing on your mind at that particular time. But, as they move away from those, it suddenly becomes what’s their functional level like, have they got a package of care…” (I3, Line 369)

5.4.1.2. Cognitive function

There were many examples observed where professionals discussed how cognitive function of an individual influenced their reasoning about rehabilitation potential. Professionals discussed associating decreased cognitive function with a person having ‘limited carryover’, and recognising that the ability to retain information relating to their rehabilitation and rehabilitation goals could influence outcomes. However, professionals also discussed that having dementia or cognitive impairment would not rule people out from having rehabilitation potential, with one of the social workers particularly linking this to people making good progress within familiar home environments.

Although professionals indicated that they would aim to flexibly interpret the influence of cognitive function on rehabilitation potential, it was also observed that professionals could create their own, often concrete, rules and ways of thinking about this. One patient was referred to the nurse assessor particularly quickly after the acute admission, with one of the reasons discussed during the morning handover being that ‘she has known dementia, an MMSE of 9 out of 30 and she wasn’t coping prior to admission’. This presented as being a quick judgement that this patient would not make further progress through rehabilitation, with a question following this relating to whether the team would just be ‘taking up a rehab bed’ if they referred her for ongoing rehabilitation.

A similar example involved the team considering the rehabilitation potential of a patient being discharged home in relation to the appropriateness of a reablement package, although instead decided a long term care package would be more appropriate due to her MMSE of 12 out of 30. Another example was noted during a morning handover when nursing staff highlighted that ‘with an MMSE of 10 we can’t really put reablement in as she won’t learn anything’.

During interviews, some professional’s highlighted cognition explicitly as one of the most important influences, linking this to the ability to learn and retain information (often termed as carryover), and the ability to understand a rehabilitation process:

> “I think definitely with the cognitive aspect of it, I would say that’s a key thing. Em…so will they be able to understand what we’re…you know, you can get the patient who can’t even follow an instruction so you think well how are we ever going to rehab this person” (I3, Line 334).
>
> “But I think the cognition side of things…if somebody…if somebody can say this is where I was a month ago, and this is what I’m like now, and I don’t want to stay like this, I want to get back to where I was a month ago” (I2, Line 454).

However, one participant did express that poor cognition should not be seen as a factor which rules out rehabilitation potential, but acknowledged this may happen, and linked this to level of experience:

> “And I think…I’ve worked with a lot of [junior staff]. And I think because I’ve worked in rehab for a long time…I think they’re much quicker to write people off, than I am. Because they’ll be…ah, the cognition, they’ve got no idea…and I think that they can be ‘oh, we’ll just monitor them, I don’t think we’re going to get anywhere with them’. Em…but people can surprise you actually…it could be that, they’ve got some delirium that is resolving, it could be that they’ve had a UTI, and

> em…within…give them a few days, and they're a completely different person" (I1, Line 285).

5.4.1.3. The importance of understanding the 'baseline'

The above factors – understanding co-morbidities and cognitive function - helped professionals to establish a picture of what they frequently referred to as the patient's 'baseline', a term used continuously within the field and one which has already received attention within this chapter. And within interviews, all participants reflected the influence of information about the baseline or a previous norm as an integral part of their reasoning about whether someone had the capacity to make gains from their current level.

Despite the importance of baseline information to professional reasoning, there were many examples of gaps or inaccuracies in baseline information. Examples uncovered, mainly through review of documentation during patient tracking, are summarised in the Table 7.

Table 7: Summary of omissions or inaccuracies with baseline information documented in clinical records (continued overleaf)

Case	Examples of information taken from clinical records	Issues noted
Patient 1	Day 0 – nursing assessment with baseline function completed at emergency care hospital Day 1 – Transferred to base ward Day 2 – medical entry (by consultant)'? usual level of function' documented. Day 2 – assessed by physiotherapist on base ward. Physiotherapy entry: 'History from family still needed'.	Baseline information not fully gathered at emergency care hospital Delay in understanding pre-admission functional level (baseline)

Patient 2	Day 0 - nursing assessment completed at emergency care hospital. Documentation of cognition ‘no problems’; continence ‘no problems’. Medical entry: ‘Need collateral history from son regarding current cognition – is she at her baseline ? ? may need CT head’. Day 1 – Documentation of discussion between medical team and son ‘Patient’s memory has been poor with a decline over the past few months. Has had reablement package previously which has been helpful’. Day 1 – Physiotherapy entry on base ward ‘Normally mobile with stick’ Day 7 – Documentation of discussion between nursing staff on base ward and son ‘Lives in a bungalow, regularly incontinent, walks with a tripod. TDS (three times daily) carers who help with ADLs’ Day 14 – Documentation of MDT discussion on rehabilitation ward – ‘? whether has had reablement or long term care package’	Inconsistent and contradictory information (particularly relating to mobility, cognition, continence and previous care package) which continued for approximately 2 weeks. Delay in gaining an accurate understanding of pre-admission functional level (baseline)
Patient 3	Day 0 - Transferred from an out of area hospital following specialist surgery. Letter of referral outlined pre-admission information and social history: ‘Functional level before admission - independent mobility no aids’. Day 4 – Physiotherapy entry on base ward – ‘Previous mobility independent no aid – fall 6-7 weeks ago. Struggled with mobility – occasional use of stick’.	Inconsistent information about pre-admission mobility level. Delay in understanding whether the patient was back to the same level

Professionals presented as being aware of the regular deficits in the accuracy of this baseline information. During fieldwork, one of the base ward doctors highlighted that ‘the baseline is not always clear and can be an emerging picture…particularly difficult with no family’. During this same conversation, the doctor discussed that baseline information should be available from (the emergency hospital), but also discussed that it is not always available and it is not always accurate.

The base ward team regularly referred to gaining ‘collateral history’ (a term used for a full history provided by an informant) and used different strategies such as verbal discussions with family members or use of a questionnaire completed by a relative or carer. Responsibility to gain this collateral history was observed as being shared amongst the team although multiple challenges were observed with this: different professionals gaining varying degrees of information; instances where professionals wrongly assumed others were taking responsibility; limitations with how this history was documented in notes, and examples of professionals on new wards (following a transfer from the base ward) repeating the gathering of background information from a relative or carer.

Another area observed related to how the difference between current and baseline levels could be open to subjective interpretation. This was illustrated during the tracking of Patient 5:

> The initial physiotherapy assessment for Patient 5 was completed at the emergency hospital the day after admission and the patient’s mobility was documented at this time as ‘Assistance of 1, typical PD gait’ and recorded the judgement of ‘likely baseline’. Despite this early impression, the patient remained in hospital (with a short stay in the Emergency Hospital and longer stays on the base ward and rehabilitation ward) for over 5 weeks, with ‘more physio’ and ‘continue progress mobility’ regularly cited in the clinical records and with a statement 13 days after admission ‘for home when physio feels is at baseline’.

Other examples noted throughout fieldwork suggested differences from current and baseline levels. For example, a patient recorded as previously ‘independent furniture walking’ was assessed during admission as ‘mobile with a handhold assistance of one’. Similarly, a patient who was noted as being ‘mobile independently with a wheeled zimmer frame’ and assessed during admission ‘mobile with a wheeled zimmer frame and assistance of 1’. When the researcher asked professionals what they perceived the differences to be, they acknowledged that this could be open to interpretation.

5.4.2. Engagement with a rehabilitation process

5.4.2.1. The influence of the response to rehabilitative interventions

Professionals were continuously reviewing their judgement and evaluation of rehabilitation potential based on how the person was engaging with the rehabilitation process. The physiotherapist on the base ward highlighted this during a discussion about Patient 2 where he discussed that it was ‘early days’ and went on to say that ‘until I see that progress, that initial “this is where we are”…I can then make that decision [about rehabilitation potential]’. An occupational therapist on the base ward also emphasised this saying that she ‘would have to see them’ in order to make a judgement about rehabilitation potential, suggesting that such judgements cannot be reached on background information alone but instead are influenced by a patient’s response to, and involvement in, therapeutic interventions.

A critical issue for practitioners on the base ward lay in their reflections that they often did not feel they could deliver rehabilitative interventions, despite recognising that delivering this influenced their judgement about a patient’s rehabilitation potential and therefore in turn, significantly influenced what happened next for patients. Illustrative examples of this have been provided in other sections although include professionals discussing the base ward as ‘more about discharge planning than rehab’, and also captured by a nostalgic discussion with one member of staff on the base ward which began ‘when we were a rehab ward…’.

5.4.2.2. Allowing time

On both the base ward and the rehabilitation ward, professionals often expressed needing time to make decisions about rehabilitation potential and pathways, alongside time for rehabilitation itself. Frequently within morning MDT handovers and weekly

MDT meetings, a plan for ‘more time’ was communicated verbally and in writing. Specific examples included professionals indicating that they needed ‘more time’ to assess appropriateness for transfers to other wards; plans from weekly MDT meetings documented as ‘more time’ (or sometimes more specifically ‘more time with PT’ or ‘more time with OT/PT’); and a patient with fluctuating delirium discussed in a weekly MDT meeting with the summarising comment stated as ‘watch and wait’.

As with the base ward, the team on the rehabilitation ward also expressed similar statements about planning ‘more time’, and this seemed to be discussed anew on transfer to this ward. However, it was noted that on the rehabilitation ward, the expressions were often more specific and time-framed than the examples observed on the base ward. For example, at the first weekly MDT meeting following Patient 2’s transfer, the consultant verbally discussed that she was ‘not sure what her rehab potential is…give her 2 weeks and review’.

This desire for more time was often understandably linked to the need to assess and judge how patients responded to rehabilitative interventions. Time was also seen to equate with the provision of a rehabilitation process of an appropriate quality. For example, when asked to describe rehabilitation, one interview participant expressed a direct link between the concept of rehabilitation and a process allowing and affording time:

> “The way I look at rehabilitation is having time to work with something… even if you look at a ward handover it just says ‘rehab’…which it just sort of…we all understand it that they need more time with the physio or the OT, that’s how it’s understood” (I5, Line 22).

If professionals felt that affording time was linked to the quality of rehabilitation, this perhaps contributed to feelings of compromised or improper rehabilitation when time was inevitably pressured. During a discussion with the base ward physiotherapist, a desire to provide intensive rehabilitation was expressed but coupled with a suggestion that they did not have the time for repeating activities such as standing practice or passive movements several times per day. Feelings that the amount of time allowed for rehabilitative interventions was unsatisfactory was also reflected during interviews:

> “It’s working with them daily, having daily input with that person, practicing tasks, so that they can…possibly become independent or improve in their independence in that area that we’re looking at. But that relies on having the time to do that” (I5, Line 24).

5.4.2.3. Mood and motivation to engage

Professionals regularly discussed the importance of mood and motivation as factors which influence their judgement about rehabilitation potential. One physiotherapist discussed her thinking that ‘a big part of it is…motivation and [the patient] understanding what we’re trying to achieve…if we can do that things work a lot better’. And when reflecting on Patient 2, the same physiotherapist mentioned that her mood was very low, mentioning this before other things that may be influencing what she was thinking about the progression and potential of this patient.

This also seemed to be the first thought of other professionals on other occasions – for example during an interaction with an occupational therapist at the intermediate care unit, when asked to bring to mind people who had good rehabilitation potential, the first thing she mentioned was ‘someone who is motivated’. Another physiotherapist, through her own words, placed emphasis on the importance of mood suggesting that ‘her mood has got a massive amount to play in it [her rehabilitation potential]’.

Interview extracts also emphasised this as a prominent feature of professional reasoning:

> “I still think this [motivation] is a really big one” (I1, Line 329).

> “I think the main thing is people’s engagement and how, you know, focussed and willing they really are to want to engage in rehab” (I4, Line 170).

A related issue noted during fieldwork was the extent to which professionals felt that low mood and motivation was something which could be improved in order to positively influence rehabilitation potential and subsequent rehabilitation outcomes. In the earlier section relating to the meaning of rehabilitation, it was noted that a rehabilitative approach to mood and anxiety problems, such as increasing 1:1 time with staff or social activities within the ward, was seen as something that would be ‘nice to do…but not realistic’.

Another example, in relation to Patient 2 during her time on the rehabilitation ward, involved the physiotherapist reflecting that ‘it might be better if can try and get her moved in to the bay where she’s actually got some company’. Although the physiotherapist then followed this by adding ‘unfortunately a lot of people in the bay need to be in the bay….but it’s something to just keep an eye on’. The move in to a bay did not happen for this patient whilst they remained on the rehabilitation ward and was not documented as part of a proposed plan in her clinical records.

5.5. Chapter summary

This chapter has presented a multi-dimensional understanding of rehabilitation which emerged from the thematic analysis. Although the data relied heavily on time spent and perspectives shared with occupational therapists and physiotherapists, the dominant discourse amongst all professionals was that rehabilitation was a professionally-led process, predominantly led by physiotherapy, to promote improvements in physical abilities. This was linked in part to physiotherapy being involved earlier and more frequently in the delivery of rehabilitation interventions. Professionals described aspirations or ‘gold-standard’ versions related to rehabilitation although often realities did not correlate to these ideals. The examples and wider implications will be critically examined in the discussion chapter.

Rehabilitation potential was recognised as an ambiguous concept which in practice often lacked specificity. Interestingly, the overlapping nature of evaluations of rehabilitation potential and decisions about transfer of care contributed to the evaluation of rehabilitation potential bearing responsibilities of gatekeeping, which subsequently linked to the decisions being controversial and open to challenge. Through speaking in the third person, interview extracts provided insight that professional ownership of these challenges may be difficult. This leads in to the next findings chapter which presents the ethical dimensions and tensions of professional reasoning in relating to rehabilitation decision-making.

CHAPTER SIX – RESEARCH FINDINGS: THE ETHICAL DIMENSIONS OF EVALUATING REHABILITATION POTENTIAL

6.1. Chapter introduction

The influence of ethical dimensions on practitioner reasoning emerged as significant during data analysis and is presented as one of four over-arching themes. Subthemes will explore how practitioners considered the consequences of an evaluation of rehabilitation potential – such as the desire to bring about a positive outcome for patients and the desire to minimise harm – and how values placed on such consequences were enacted in practice. Furthermore, it was an initial objective of this research to understand patient involvement in the evaluation of rehabilitation potential and subsequent pathway decisions, and sub-themes pertaining to this important element will be developed. Finally, how professionals were managing ethical dimensions will be discussed. Once again, the process of using early codes to develop themes and subthemes is illustrated in Figure 10.

Figure 10: Coding and theme development – ethical dimensions of evaluating rehabilitation potential

Early Coding:

Whilst using the initial code of ‘decision-making’, different ethical dimensions were recognised within the data. A new code of ‘ethical dimensions’ was then utilised to review the whole data set.

Ethical dimensions:

- Aiming for a good outcome
    - Giving people a chance
    - Not ‘writing people off’
    - (Absence of) goal setting
- Avoiding harm/managing risk
- Blurring of doing good and avoiding harm
- Involvement
    - Is desired
    - Not routine
- Patient Involvement
    - Secondary to family involvement
    - If disagree – question capacity
- Family involvement
    - Surely they should know?
    - Default position?
- Barriers to involvement
    - Time
    - Lack of alternatives
    - Not wanted?
    - Those who speak up are privileged
- Rationing
    - Involvement becomes rationed
    - Record keeping rationed
    - Rehabilitation as a rationed resource
- Fairness to older people
- Professional experiences of ethical distress

Examples from the data:

Ethical Dimensions

Aiming for a good outcome/giving a chance: Fieldnotes p70 ‘giving people a chance’

Not writing people off – Fieldnotes p163 “I don’t think you can write people off”.

Avoiding harm – Fieldnotes p168 “It would be a shame for her to go home with a full-body hoist”

Blurring of doing good and avoiding harm – Fieldnotes “It’s a bit of a fine line when somebody’s getting very very upset though and saying that they desperately want to get home”

Involvement desirable – I1 “I think we all want this ideal text-book thing”

Not routine – I2 “sometimes we give the illusion of involvement in that decision but I think some of the time that decision has been made”

Patient involvement secondary to family: Fieldnotes p188 “Providing family are happy and she is happy”.

Surely they should know – Fieldnotes 190 “family have seen her everyday, surely they should have seen this?”

Default position – I5 “We definitely speak to the family more”

Barriers – I5 “I don’t really think patients and families have a lot of say in that, no. I guess…there’s limited resources”

Ethical distress – I4“It really makes me uneasy when I have to like compromise my therapy for bed pressures”

Final themes and Sub-themes:

Theme: Ethical dimensions of evaluating rehabilitation potential

Sub-themes:

- Brining about a positive outcome
- Avoiding harm
- The blurring of doing good and avoiding harm
- Autonomy and involvement
- Fairness and rationing
- Professional tensions and discomfort
- Strategies for dealing with competing demands and ethical tensions

6.2. Bringing about a positive outcome

The desire that the provision of rehabilitative interventions would lead to eventual improvements for individuals, and therefore positive outcomes, was clear through all aspects of fieldwork. Professionals regularly expressed their desire to bring about functional improvements in terms of giving people ‘a chance’; that is to say, they wanted to optimise the likelihood of improvements through the provision of rehabilitative interventions and the creation of rehabilitative conditions. Professionals also linked a positive evaluation of rehabilitation potential as a gateway to the provision of a rehabilitation resource, and therefore as a key part of increasing the likelihood of improving outcomes.

When talking about the judgement about rehabilitation potential for Patient 1, and reflecting on the reasons for listing her for the rehabilitation ward, the physiotherapist on the base ward discussed wanting to give her a chance to make further improvements. Similarly, when discussing beginning to reduce physiotherapy input for Patient 2 towards the end of her admission on the rehabilitation ward, the physiotherapist discussed that she would listen out at the morning handovers for any sign of improvements because she always wanted to ‘give people a chance’. This was echoed by wider team members when one social worker discussed how she thought ‘everyone deserved a chance’.

Although goals of rehabilitative interventions were not always explicitly stated, the primary purpose of a rehabilitative phase of care, understood through many observations and interactions during phase 1 and 2 of fieldwork, was to work towards functional and mobility improvements to achieve as close to baseline function as possible. This represented an implicit understanding that this represented a positive outcome for the patient.

At this point, information about functional status available from the five patient cases tracked during phase 2 of fieldwork is worthy of note. Table 8 below summarises information in relation to the functional level at the point of initial therapy assessments, the optimum or best functional level noted during the whole episode of care, and the outcome at the end of tracking.

Table 8: Summary of information obtained from clinical records documenting optimum functional level of patients tracked during phase 2 (continued overleaf)

	Notes taken from documentation of initial PT assessment	**Notes taken from documentation of initial OT assessment**	**Optimum level during admission documented in medical records**	**Outcome at the end of tracking**
Patient 1	Sit to stand independently Assistance of 2 for standing balance Mobile 4m with Assistance – requiring oxygen	Due to existing carer support from daughter and existing equipment, no OT needs identified at time of initial assessment	Optimum sit to stand noted as independent on admission. For mobility, minimal assistance of 1 and walking aid noted throughout admission Ongoing reduced exercise tolerance	Died on rehabilitation ward (length of admission 52 days)
Patient 2	Sit to stand with assistance of 2 and 4 wheeled walker Mobile 5m with assistance of 1 and 4 wheeled walker	N/A	Sit to stand with maximum assistance of 1 Mobile 6m with maximum assistance of 1 and wheeled frame	Inpatient on rehabilitation ward. Awaiting 24 hour nursing care No longer receiving active therapy Using full body hoist for transfers
Patient 3	Sit to stand with supervision Mobile with delta frame 40m	Home equipment in situ. Query whether at baseline	Sit to stand independently Mobile independently with a frame Independent bed transfers	Died on base ward (length of admission 26 days)

Patient 4	Mobile 6m with wheeled frame and assistance of 1 but shortness of breath on exertion noted	Bed transfers with assistance of 1. Query about bathing transfers	As noted during initial PT and OT assessments	Discharged home (length of admission 12 days) NB – readmitted and died during subsequent admission
Patient 5	Assistance of 1 lying to sitting Sit to stand with assistance of 1 Mobility with assistance of 1	Issues noted with transfers and carer support. Assistance of 1 for bed transfers and manoeuvring in bed	Lying to sitting to standing independent with raised bed and bed lever Sit to stand from chair with assistance of 1 Mobile independently with delta frame	Discharged home from rehabilitation ward at optimum level.

It is important to emphasise the small number of patient cases, the limitations of using narrative information from clinical records (as opposed to valid outcome measures at points of care delivery and transfer), and the many influences on patient outcomes linked with frailty and co-morbidities. And this is presented as a partial account only, due to the fact that I could only ever understand the parts of the episode of care that I observed, or the representation that was captured in clinical records. However, this summary highlights that three of the five patients had died by the end of tracking and one was documented to be at a lower functional level and awaiting 24-hour nursing care, and suggests that reasoning which was highly influenced by a desire to give people a chance of positive outcomes through a period of rehabilitation warrants critical reflection.

6.3. Avoiding harm

Practitioners were aware that an evaluation of rehabilitation potential, potentially influencing whether a person would then receive a further rehabilitation service – either bed-based or otherwise – also had the potential to cause harm. Similarly to the way a positive evaluation of rehabilitation potential was attributed particular vocabulary around being given ‘a chance’, a negative evaluation of rehabilitation potential was often discussed in terms of people getting ‘written off’. In simple terms, practitioners placed value on the ability of rehabilitation to bring about improvements and therefore were aware that withholding or denying a person access to this could result in a missed opportunity for improvements and potentially a negative outcome. This was expressed by one physiotherapist in relation to Patient 2 whilst reflecting that she had reached a plateau although they did not want to conclude their interventions at this point because ‘it would be a shame for her to go home (with a) full body hoist’. This mobility status of using a hoist – which was different to how this patient mobilised or transferred prior to admission – was perceived as a negative outcome and one that could be potentially remediated through further rehabilitation.

The consideration of the rehabilitation pathway was also influenced by awareness of harm and risk. The below vignette illustrates how the decision about the rehabilitation pathway also become a decision about how to manage risk:

Patient 5 was transferred to the base ward 2 days after his emergency admission for a suspected stroke or seizure but what was later determined to be a worsening of symptoms associated with Parkinson’s Disease. He spent 21 days on the base ward with a main focus on stabilising the symptoms of Parkinson’s Disease through medication management and optimising his mobility and transfers. During this time, there was significant discussion in MDT meetings and morning MDT handovers about whether he would be discharged home directly from the ward, with one of the main concerns being the ability of his wife to meet his care needs as this had been raised as a concern prior to admission.

A planning meeting was held 9 days after his admission (7 days after his admission to the base ward) where a potential care package on discharge was discussed although no firm timeline or pathway decisions were made. Notes about this planning meeting consisted of a brief entry in the medical records.

He was subsequently listed for the rehabilitation ward 18 days after his arrival on the base ward and when this decision was made, the occupational therapist reflected ‘from his condition and just from what the nurses have said, I didn’t think he probably had that much [rehabilitation potential]. His Parkinson’s is meant to be better managed now and from what I saw, his mobility and function were still quite poor. I don’t think there’s possibly going to be that much change and my main concern around him going home would be the wife’. This was echoed in discussion with the physiotherapist on the base ward who indicated that ‘if [Patient 5] lived on his own, we may have been able to get him home with a big care package’.

6.4. The blurring of doing good, and minimising harm

Professionals did recognise that this ongoing desire to work towards improvement could potentially become negative. One physiotherapist raised the professional challenge of at ‘what point do you draw the line?’. On further discussion with this professional, tensions were discussed between the desire for improvement potentially becoming harmful for the individual (for example by contributing to a longer hospital stay or unrealistic expectations), or potentially harmful for those individuals not receiving services because the time of the physiotherapist was being allocated to this person. Such discussions provided insight in to the pressure felt by individual professionals to maximise positive benefits and minimise harm when making decisions about continuing and concluding rehabilitative interventions.

Observations and discussions suggested that giving people ‘a chance’ was often associated with a longer hospital stay because of a professional belief that this represented the best chance to bring about a better outcome. This was captured by the physiotherapist on the rehabilitation ward in relation to Patient 2: ‘It’s a bit of a fine line when somebody’s getting very very upset though and saying that they desperately want to get home…sometimes you think, is it better to get someone home as quickly as possible even if it does mean them being hoisted and not reaching their potential or is it better to keep them…to work on that and to try to get them better. I think…if we could keep her for a bit longer, I think we probably will get there'.

A positive evaluation of rehabilitation potential in order to access a rehabilitation bed to afford time and manage risk was seen to have the potentially harming effect of raising expectations for patients and families. When Patient 5 was asked by the researcher what he understood about why he was transferred to the rehabilitation ward he indicated 'to get stronger'. Following this, on the first working day following his transfer to the rehabilitation ward, the new physiotherapist involved in his treatment discussed planning to assess him that day to 'look at bed transfers and to try with a delta frame' which presented as indicating a new assessment of potential and potentially new rehabilitation goals. As outlined in the vignette on page 177, this presented as being out of line with the reason for transfer to the rehabilitation ward communicated by the therapists involved on the base ward which was primarily to ensure his care needs and social situation could be managed safely. I did not observe this reasoning discussed verbally between professionals on the base ward and the rehabilitation ward and it was not explicitly documented within clinical records. In comparison, the patient's understanding was that he was being transferred in order to work towards getting stronger, and the assessment commenced by the new physiotherapist also presented as being aligned to this.

A similar issue was noted with another patient when, during a discussion with the base ward physiotherapist before his transfer to the rehabilitation ward, it was highlighted that 'his family want him to use the stair lift…this might not be realistic but it's something for [the rehabilitation ward] to look at.

6.5. Autonomy and involvement

To begin this sub-theme, it is important to note that patient and family involvement was seen as a desired and ‘ideal’ feature of rehabilitation, although it was also understood that this was perhaps not always happening in this desired way. This was summarised during an interview:

> “I think we all want this ideal text book thing…you know, goal-led, get the carers, get the family members, get the patient, do it all together. But it’s not always as easy as that. Unfortunately” (I1, Line 258).

6.5.1. Involvement in evaluations about rehabilitation potential…rehabilitation what?

The concept of rehabilitation potential did not appear to be one that was explained or translated explicitly to patients and families, or indeed a concept that patients and families were encouraged to consider. Therefore I did not observe patients or families making an explicit contribution to this judgement. Instead, it was observed that when rehabilitation potential was deemed to have been reached, this was then subsequently explained to patients or families.

This was observed in the example of Patient 1 who had a lengthy hospital admission (approximately 7 weeks) with periods of acute medical issues including aspiration pneumonia and cardiac events. During this time, there were discussions amongst the team questioning and reviewing rehabilitation potential. However, it was approximately 6 weeks in to the admission that an explicit entry was made in the patient’s medical notes to record a conversation between the occupational therapist and the patient’s daughter that further progress through rehabilitation was unlikely.

Although the content and timing of this discussion was logical, and did fit with the process presented in Figure 5 (which outlined that time is needed to treat and overcome medical issues and to monitor the extent of progress through engagement with a rehabilitation process), it was not made explicit within documentation that the earlier stages of this process (that is to say the time needed to evaluate potential and that the team would be looking for specific progress towards identified goals) were communicated to Patient 1 or her daughter.

Linked to this, when rehabilitation potential was deemed to have been reached, this was not always fully explained to patients or families. For example, the physiotherapist from the rehabilitation ward discussed that Patient 2 had no further rehabilitation potential and when asked whether this had been discussed with family members the response was ‘No [not] at this stage…but they have seen her every day…surely they should have seen this’. This suggested that the family in this example were left to interpret for themselves that further functional gains were unlikely.

A potential outcome of patients and families implicitly understanding such judgements was expressed during an interview, where the health professional expressed a difference between the professional evaluation of rehabilitation needs and potential and that of a family member:

> “Now his mum was in her nineties and was really quite frail and you think…well how could you possibly expect that your mum could cope with 2 hours of physiotherapy a day. Because that’s just completely unrealistic” (I1, Line 499).

6.5.2. Involvement in pathway decisions

During observations, I did not witness a clear approach to involving patients and families in decisions about their pathway, transfers to different locations, or what services they would receive. There were places where this was happening, and many professionals could potentially be involved in different ways at different times, although the potential for gaps and variances was also noticeable.

A movement or transfer within the pathway often involved an onward referral (for example to list for another ward or to refer to another service such as social work or the reablement team) and therefore one of the first considerations relating to involvement in such decisions was the issue of consent to such referrals. Consent to list for other wards or to refer to another service such as social work was not witnessed clearly during observations, or explicitly found to be documented in any examples of records viewed during patient tracking. During an informal discussion with a social worker, she reflected that often the ward do not tell people they have been referred to social work and reflected that one consequence of this is that it is then difficult for her to introduce herself. Other staff also acknowledged that consent for such services tends to be assumed, linked to an assumption that people want whatever it takes in order to get home.

Outside of consent for onward referrals, discussions with patients and relatives about transfers to other wards were also not always apparent. In the case of Patient 1, during her 23 day stay on the base ward, there were many times that decisions were reviewed in relation to her pathway and potential transfer of care. Transfer to the rehabilitation ward, transfer to the intermediate care unit, and discharge directly home from the base ward were all verbally discussed and documented in records, normally preceded by the '?' symbol in the written records. However, there were no clear entries in the medical records to confirm that these alternatives were discussed with the patient or her family members.

In the case of Patient 2, a transfer from the base ward to the rehabilitation ward was first discussed 4 days after admission and documented in the medical notes from the MDT meeting as a possibility (noted : '? Ward ** [the rehabilitation ward]'). Following a ward round with the consultant 2 days later, this decision was confirmed and the patient was listed for transfer. Discussion with the nursing team indicated that the ward clerk would then contact the bed managers to list for the transfer and if a bed became available, the ward clerk would then contact family members to inform them that she was being moved. However, the fact that this was delegated to the ward clerk and occurred at the point of transfer, implied that this was to inform them of the move rather than to discuss the reasons for the move, or their wishes in relation to this.

6.5.3. Patient involvement after decisions

One of the issues noted most frequently was that during discussions about potential transfers to other wards or services, the decision or action tended to be made first with the views of patients and families noted afterwards (see examples in Table 9)

Table 9: Examples illustrating patient involvement after decisions

Context	**Extract from Fieldnotes**
A patient discussed in a base ward MDT meeting	Consultant: ‘Here or [the intermediate care unit]…if they have beds at [the intermediate care unit] and she is happy to go this seems like a plan’
A patient discussed in a base ward MDT meeting	Consultant: ‘[Name of intermediate care unit] if patient agrees’
A patient discussed in a base ward MDT meeting	Consultant: ‘Can list for [rehabilitation ward] if she’s happy’
A patient discussed in a rehabilitation ward MDT meeting whether would be a candidate for the specialist unit for cognitive assessment and rehabilitation. Team discussion that the Modern Matron had asked if she can just go straight there.	Nursing: ‘Hang on – no-one has discussed this with the lady or family’

In all of the examples above, the decision was noted or stated first, and the issue of consent from the patient was a secondary point. And the final example illustrates that, at least on this occasion, the team were aware that this was happening.

6.5.4. Patient involvement after family involvement

There were also similar examples where the views of the family were acknowledged first, with the views of the patient either mentioned afterwards or not at all (outlined in Table 10).

Table 10: Examples illustrating patient involvement after family involvement

Context	**Extract from Fieldnotes**
A patient discussed during an MDT morning handover	Nursing: ‘Patient listed for [intermediate care unit] and family are in agreement’
A patient discussed in a rehabilitation ward MDT meeting whether would be a candidate for the specialist unit for cognitive assessment and rehabilitation (as above)	Consultant: ‘Provided the family are happy and she is happy [the unit] seems reasonable’.

The essence of these issues was perhaps insightfully illustrated by a discussion in a base ward MDT meeting about whether to repatriate a patient who was out of area to her local general hospital. After lengthy discussion the consultant asked the team ‘What does she want?’, to which a member of the nursing team responded ‘don’t know…we haven’t asked her’.

The issue of involving family members – either before, or instead of, patients themselves, was also reflected during interviews:

> “I think we’re all guilty sometimes of just…homing in to the family member and…kind of forgetting that that person’s there and is taking it all in. I would like to think that the wishes of the patient are taken as top priority but I think, especially in elderly care, quite a lot of the time, it’s what the families think and kind of not what the patient either wants or feels” (I1, Line 576).

6.5.5. The vocal and not-so-vocal

There were some occasions where patients or family members were observed to vocalise their wishes about their pathway and place of care and this directly influenced outcomes and decision-making. For example, a patient who was deemed to have rehabilitation potential by the team, and that a transfer to the rehabilitation ward would be appropriate, subsequently made her wishes known to the consultant that she would prefer to stay on the base ward. Following this, the team decided that it would be appropriate for her to stay and she remained on the ward for a further period of rehabilitation and discharge planning. Similarly, there was an example where the team on the base ward proposed listing a patient for a continuing health care bed in a local nursing care environment although at a morning MDT handover meeting, a member of the nursing team discussed that when this was mentioned to family members they said 'no way…they think it's filthy'. Again, this subsequently altered the course of action and led to the team considering alternative pathways.

Within interviews, when asked about involvement of patients and families in decision-making, the stories that were most forthcoming were about situations where patients – or more often families – became vocal. There were two reoccurring perspectives within these stories: that those who were vocal often became so because of issues of a more negative nature; and that those who were vocal were often more involved or more listened to than those who were not. The extract below illustrates these issues:

> "Often, I almost feel like the patients who might stay on a ward longer than perhaps the MDT would suggest, it's because their family have stomped their feet and actually they might kick up a bit of a fuss if the patient was to be discharged home in whatever functional status they're at. So, it's probably those families and patients who get listened to more than others who perhaps don't kick up a fuss and don't em…create problems" (I5, Line 36).

A particular extract develops this further, with language suggesting that this type of involvement can become confrontational and challenging:

> “But families are sort of quite demanding about, you know, my mum needs to be in 24 hour care, there’s no way she can cope at home. Em…like an example I could give of that from a few weeks ago...and [at one point] I had basically been dragged in to an inquisition by the daughter and the son with the Physio. They’d turned up on the ward and demanded that we had a planning meeting and we were the only 2 people there so we sort of got sent in like lambs to the slaughter (laughs)” (I2, Line 736).

Despite this, there were other examples within observations where patients and families attempted to vocalise a preference in relation to their place of care and this did not influence the outcome. A patient on the base ward, who had been transferred from another local hospital and also had internal transfers between wards during his admission, was discussed as being appropriate for another transfer to the rehabilitation ward. It was discussed at the morning MDT handover on the base ward that he did not want to go to that ward although a member of the team indicated ‘it doesn’t really matter to him…it’s just a bed’ and he was subsequently listed for the transfer.

6.5.6. Reasons for limited involvement

6.5.6.1. Not wanted?

Although there were examples where patients and families demonstrated vocal involvement in decisions, some patients and families were observed to be more passive, or to occasionally actively avoid involvement. During fieldwork observations, the team on the base ward shared examples where relatives would not return calls, or not attend meetings on the ward and the team linked this to not wanting to be involved in decisions or to potentially creating barriers to decision-making.

Patient 5 declined to attend a planning meeting being held on the rehabilitation ward to plan his discharge, instead suggesting that his son and wife would attend and represent him. When asked about this, this patient indicated that he would find it difficult to attend a meeting where all of the discussion was about him. In the case of Patient 2, there were multiple times when family members presented as experiencing difficulties taking responsibility for particular decisions – asking for delays to a decision about resuscitation status and not wanting to take the responsibility for consent to psychiatric assessment or commencement of anti-depressant medication.

Professionals shared reflections about why patients and families may not want to be involved in decision-making. Participants indicated that patients and families may revert to understanding of traditional hierarchies and feel that professionals who hold specialist knowledge should also have responsibility for decision-making:

> “You get those people who simply say ‘fix me’, I don’t care what you do, you just fix me” (I3, Line 708).
>
> “And some families seem to have that old fashioned view that the doctor knows best and if the doctor tells you then that’s what you do, or the professional…and they think you’ve got the right answers because you’re the professional and they don’t need to weigh in” (I5, Line 403).

Another extract from an interview suggested that involvement in healthcare decision-making can feel unfamiliar and overwhelming and again, this may explain why some patients and families present as not wanting to be involved:

> “Some families I think…the whole hospital environment is quite alien to them and they don’t really know how it all works” (I5, Line 402).

6.5.6.2. Rationed out?

From fieldwork observations, I became aware that meaningful involvement of patients and family members involved time-intensive activities – such as discussions, joint therapy sessions and telephone calls – and in a highly time-pressured environment, an obvious consequence was that such activities may subsequently be rationed.

This impression was supported when professionals were encouraged to explore this issue during interviews, with one participant in particular highlighting the issue:

> "Because if you've got 28 people on a ward, you haven't got time every day to be going to see families and to update…it just isn't possible you know….Sometimes, it's just not as easy as…as you think you know. And if you…if you do a joint session with a family, that could take you an hour really. Because you'll be explaining lots of things, and so…you couldn't do that every day, do you know what I mean?" (I1, Line 523)

Also, one participant suggested that it may not only be activities involving patients and family members which are rationed due to time, but also, the documentation of these activities:

> "So I guess you do tend to sometimes fall in to, I'm in a rush, there's no point in me writing 3 pages when I can write 2 lines" (I2, Line 354).

6.5.6.3. Lack of meaningful alternatives?

Another explanation for why meaningful involvement in decisions pertaining to rehabilitation pathways was challenging in this context was that there were a perceived lack of alternatives which may have resulted in involvement of patients and families feeling futile. Professional perspectives shared during interviews suggested that historically, discussions with families may have involved the presentation of different alternatives, although those alternatives may now not be available and therefore the discussion itself may not take place:

> "I would have always considered if there was going to be beds available but now we know that it's so constrained, that there is such limited availability that sometimes you can't even consider that as an option because you know it's not an option" (I5, Line 227).

6.6. Fairness and rationing

Evaluations of rehabilitation potential and the subsequent recommendation about an appropriate pathway inevitably involved decisions relating to resource allocation and fairness. At the level of the organisation, it could be perceived that the closure and re-provision of the bed-based intermediate care unit and the re-provision of the identified rehabilitation ward in to a ‘discharge ward’ were linked to the allocation of finite resources and the setting of organisational priorities.

Individual practitioners were continuously making decisions in order to allocate finite resources. Both physiotherapists and occupational therapists discussed how they prioritised their daily caseload, how they delegated work to assistants and how they prioritised patients for therapeutic input at weekends, all informed by implicit evaluations of who had potential to gain most and underpinned by attempts to distribute and maximise finite resources.

Wider examples of resource allocation and rationing have been illustrated in earlier sections. For example, onward referrals for rehabilitation or reablement for those with significant cognitive impairment could sometimes be ruled out based on decisions that these individuals may not benefit from this limited resource. Therapeutic interventions to address mood and social interaction were deemed to be desirable aspects of rehabilitation, but areas that practitioners felt unable to prioritise. Similarly, the approach for managing referrals to occupational therapy meant that any patient already living in a nursing or residential care environment was judged not to be a priority and therefore either not referred, or referred back to the original referring agent. Also, activities which involved relatives and carers – either in direct therapy sessions, or in discussions to aid decision-making – were discussed on some occasions as not being a priority. Importantly (and particularly related to this study which utilised care records as a means of gathering information) limited detail in care records was also linked to rationing by some professionals, with time being prioritised towards other activities.

Some examples of rationing were also so implicit that it was only through brief interactions that they became momentarily detectable. During one interaction, I was discussing prioritisation for weekend physiotherapy with the base ward physiotherapist. The physiotherapist acknowledged there were patients who would ideally be listed for weekend physiotherapy if they had more staff, however because this decision not to list had unnoticeably already been made, it subsequently was not documented nor discussed with the weekend team. And perhaps most importantly, the patient did not know that they had been considered for, or could have received, this intervention.

The specific issue of allocating time for the rehabilitation of elderly patients was raised as a critical challenge during one interview, suggesting rehabilitative interventions for this population took more time than rehabilitation for a younger population and this led to questions about the fairness to others of allocating time in this way:

> “You might have rehab with a younger person that takes you half an hour, forty minutes…and the same rehab session with an older person might take you the entire morning…I think…if you have twenty…I think it was 29 patients I had…you know, you have to try and balance what’s happening with everybody” (I2, Line 45).

The influence of the organisation can be seen in one example previously presented (page 159) where the base ward physiotherapist reflected on the prioritisation of daily workload and how seeing those patients who could be moved on in the shortest time was more of a priority than seeing new patients on the day of admission.

6.7. Professional tensions and discomfort

Throughout the phases of fieldwork, the problematic nature of balancing the inevitable tensions of the needs of the individual, the needs of the organisation and professional values and integrity were frequently discussed. On many occasions, professionals described visions of what they would like to happen in comparison with what was happening in reality (examples noted in section 6.2.5).

Frustrations due to limitations with time and resources and the subsequent perceived failings with the system were frequently expressed – sometimes directed at the system as a whole and at other times, directed at particular services or professions. A ward doctor captured overall frustrations with care of older people in general when he shared that the “most likely outcome…home with increased care and some OT equipment, back within a fortnight and go to 24 hour care. That’s my cynical care of the elderly assessment”. And one physiotherapist discussed being acutely aware that ‘it all comes back to money and resources’ and expressed the tension with doing what is best for individual patients.

On other occasions, such frustrations were directed towards identified services or individual professions. For example, one professional expressed an opinion that length of stay meetings had come about by delays or deficiencies in the social work service stating ‘this is why you have length of stay meetings…social, social, social, social’. And when discussing the involvement of a team to provide mental health liaison services, during a base ward MDT meeting it was commented that ‘all they have done is stick an assessment from May in the notes’.

The theme of professional frustration – and sometimes associated guilt - was then communicated strongly during individual interviews when perhaps the act of discussing this in a private space and away from clinical duties, promoted reflection on these issues in a more personal way.

> "I think we are all guilty of that sometimes (focussing on talking to families because it is quicker or easier to do that collaborating with patients)…I always feel awful when I've done that…but sometimes it just happens" (I1, Line 576).
>
> "And the problem that I have with that (rehabilitation aiming for safety rather than improvement back to baseline) is that I sort of feel that we're failing patients because….patients aren't getting rehabbed back to baseline…in terms of mobility and things. That then has a huge impact on their other functional activities of daily living" (I2, Line 80).

One participant expressed the direct link between the allocation of resources, the options that could be available to people and the professional frustrations experienced:

> "I think resources again…frustratingly…is something that we really have to think about in terms of pathways. I would have always considered if there was going to be beds available but now we know that it's so constrained…sometimes you can't even consider that as an option because you know it's not an option" (I5, Line 224).

Responses suggested that such frustrations could also be linked to conflict with others:

> "Because, if everyone's on the side of this person doesn't need to be here any longer and you're the lone voice saying 'hang on a minute I still think they have potential…we should give them another few days'. Then sometimes you're the person who's spitting in the wind basically" (I2, Line 567).

At other times, interview responses suggested feelings which went beyond frustrations with self, others or systems, with instead responses suggesting feelings of professional compromise and distress:

> "It really makes me uneasy when I have to like compromise my…compromise therapy for bed pressures…I don't know I just don't like talking about it and using all the terminology…I feel like patients are just numbers and it's not very patient centred" (I4, Line 138).

6.8. Strategies for dealing with competing demands and ethical tensions

6.8.1. Overt strategies

6.8.1.1. Waiting lists

The most explicit use of waiting lists could be observed in relation to patients waiting for another service within the system – such as a bed on the rehabilitation ward, the intermediate care unit or less frequently, placed on a waiting list for a service such as community physiotherapy. For bed-based rehabilitation, once the team had decided that a patient had ongoing rehabilitation potential and rehabilitation needs, a telephone referral was normally made by the ward clerk on the base ward to the bed management team in order to place the patient on a list for the identified ward or unit. Bed managers held lists for both the rehabilitation ward and the intermediate care unit (among many other wards within the hospital system) and when a bed became available, discussion with bed managers suggested that they would normally prioritise those for transfer using the date order in which they were listed.

One area of interest about waiting lists was that, on occasions, professionals were observed to reach a judgement that a person would benefit from a service but decided against placing on a waiting list because of a tacit understanding of how long the person could potentially wait and the consequences for others also listed who may be more of a priority. The base ward physiotherapist discussed deciding not to refer a particular patient for community physiotherapy mainly because the waiting list was too long and the patient would likely have improved themselves during the waiting time.

6.8.1.2. Triage

One of the most obvious examples of where triage was employed was in the prioritisation of patients for weekend therapy illustrated in the example relating to weekend physiotherapy cover below:

The researcher was present with the base-ward physiotherapist during the prioritisation of patients to be listed for weekend physiotherapy. The physiotherapist talked through all of the patients who were deemed to be appropriate to be listed for weekend physiotherapy and discussed an individually developed traffic-light system.

Patients who the physiotherapist categorised as ‘red’ were those where weekend physiotherapy was deemed as essential. Two patients were identified in this category and included a patient whose oxygen saturation had been dropping when mobilising although this had improved progressively over the previous days and the therapist did not want her to go backwards. The second patient was new to the ward that day and ‘would probably stay in bed all weekend’ if she was not seen and a moving and handling plan initiated. The physiotherapist acknowledged that patients known to be needing active respiratory physiotherapy would also be categorised as red but discussed that they did not have any patients categorised in this way on this particular day.

Patient’s categorised as ‘amber’ included a number of patients who would benefit from further mobility progression and another new patient who had not been seen but was ‘likely to be there for a while’. When asked to discuss this judgement further, it was based on previous knowledge of this patient from a prior admission.

One patient was identified as ‘amber’ for stair practice, but that this would become ‘red’ if a decision was made that the patient could be discharged over the weekend.

All other patients were identified as ‘green’ and were discussed as patients who were not benefitting from active physiotherapy (for example they were medically unwell) or where established plans were in place (for example nursing staff would be following established mobility or moving and handling plans). The physiotherapist discussed that wards all had the ability to refer to the weekend team if patients changed, or if respiratory physiotherapy was required.

The physiotherapist did discuss that if he/she was the physiotherapist providing cover at the weekend, and time allowed, some patients on this ward may be seen in addition to those listed – with additional discussion that they were already known to this particular therapist.

The discussion concluded by reflecting that each of the wards which were categorised under the ‘care of the elderly’ service would go through a similar process and that each therapist or team of therapists may approach this task slightly differently. The list from this ward would then be reviewed and negotiated with the wider care of the elderly team, with patients changed (or more specifically, the example was given that they could be removed or the status changed) depending on how realistic the full list would be for the provision of weekend input.

A similar strategy was utilised by occupational therapy, with priority given to those patients where discharge could be facilitated over the weekend period, or where a delay in assessment or intervention may mean a longer hospital stay.

Triage was also utilised as an ongoing strategy to prioritise workload during the normal working week although – perhaps because it did not have to be communicated to a weekend team, was less explicit, and less easily observed. However, because occupational therapy and physiotherapy did not operate waiting lists for assessment or therapeutic intervention, they inevitably were required to prioritise who to see on a daily basis. On more than one occasion, the base ward physiotherapist shared an anecdote that ‘80% of patients are likely to get better on their own’ and that time and priority should be given to the remaining 20%.

Many professionals – including occupational therapists and physiotherapists, but also the ward doctors and members of the social work team – utilised the formal and more informal opportunities for information exchange in order to assist them to prioritise their own workload and manage competing demands.

6.8.1.3. Reflection

Although this was voiced relatively infrequently, professionals did share the importance of reflective practice as a strategy to deal with some of the complexities associated with decision-making in their roles. In relation to one patient, the physiotherapist on the base ward shared that his own judgements about the best course of action, and negotiating this within the team, had been personally challenging and stated that it could be the focus ‘of a reflection’. The opportunity to reflect was also discussed as an element of engaging in the individual research interviews:

> “No, its interesting isn’t it, thinking about things…because you don’t really think that you’re doing all of these things as you’re doing them. But when you talk

> about them and you reflect them, it is quite in-depth isn't it…it is a lot to think about" (I4, Line 348).

6.8.2. Covert strategies

6.8.2.1. Creating narratives about patients

When tracking identified patients, and during wider time spent in handover and MDT meetings, narratives were used to describe patients, relatives or situations. Favourable language was used to describe some patients ('she's lovely', 'she's my favourite'), with less favourable language used to describe others. For those described less favourably, often a narrative was created which related to non-compliance with health professionals – with examples of patients refusing to get out bed, refusing bladder scans, refusing walking aids or refusing care packages all noted either through information either exchanged verbally or in clinical records. Such examples were also discussed in Length of Stay meetings (see examples on page 120).

One potential example involved a discussion in a morning handover where a patient was described as 'delightful' during the morning handover meeting and it was also highlighted that she was going home that day with reablement support. During a subsequent interaction with the allocated social worker, it was discussed that this patient was not deemed to have reablement needs but that the long term care package could not start until the following week. In this case, the rules and criterion for accessing reablement services presented as being interpreted flexibly for this patient.

In contrast, for Patient 4 it was documented and discussed in a morning handover meeting that this patient had previously 'refused' a care package and when asked by nursing staff to evaluate whether the patient would benefit from short term reablement services, both the allocated occupational therapist and social worker judged a referral to reablement as not appropriate for this patient due to the presence of long term care needs (for which the care package had been previously declined). Although justified in line with the purpose of reablement, this example contrasted with the earlier example in this section (where reablement was used to bridge a gap until the start of a long term care package) and illustrated how professionals were interpreting rules flexibly and subjectively in different situations.

6.8.2.2. Managing demand through information-giving

It was common that information about a service or intervention would not be communicated to patients unless it had already been decided that the person would benefit from this service. For example, during observations and, supported by responses during interviews with health professionals, information about a transfer to the rehabilitation ward or the intermediate care unit was often only either communicated after the person was identified as being appropriate and listed for a bed, or in some cases, only at the point that the bed became available and the move was imminent. In this way, patients deemed not suitable for an intermediate care or rehabilitation bed would often not be aware of the existence of these service. Moreover, for those who were waiting but a bed took longer than anticipated, the decision could sometimes be reviewed or changed without the knowledge of the patient and family.

6.9. Chapter summary

Ethical dimensions of decision-making emerged as clear and significant and manifested themselves in many ways. The understanding that an evaluation of rehabilitation potential related to maximising positive outcomes and minimising harm was evident but it was also evident that these principles were not mutually exclusive.

The analysis of fieldwork data pertaining to patient and family involvement highlighted many salient ethical issues. The concept of rehabilitation potential was not clearly explained to patients or families, presenting basic yet fundamental challenges to meaningful involvement. There were also critical challenges with meaningful and informed consent noted during observations and interviews such as consulting family members first, gaining agreement (rather than consent) after a decision was made, or attending to those who shouted loudest.

Practitioners communicated a range of emotional responses to the ethical dimensions of evaluating rehabilitation potential and making decisions about rehabilitation pathways – most notably, frustration in general, frustration directed at others and guilt. Observations also suggested different overt and covert strategies used by professionals to manage the ethical dimensions, professional responsibilities and emotional responses associated with rehabilitation decision-making.

CHAPTER SEVEN – RESEARCH FINDINGS: PROFESSIONAL ROLES

7.1. Chapter introduction

Although there were many different disciplines involved in evaluations of rehabilitation potential and recommendation of rehabilitation pathways, it was an objective of this study to particularly understand the role of occupational therapists and physiotherapists. Up until this point, whilst giving emphasis to occupational therapy and physiotherapy, many themes are developed across the two main professional roles and set against the backdrop of a multi-disciplinary social space.

Because of the stated commitment to understanding the occupational therapy and physiotherapy roles in depth, the final element of analysis emphasises issues affecting the two professions at the centre of this enquiry. The difference in professional roles is developed as an important theme, with instances used to develop issues of similarity and divergence.

Figure 11 provides the final example of how codes were developed and final themes and subthemes confirmed.

Figure 11: Coding and theme development – professional roles

Early Coding:

All data was reviewed using the code ‘professional roles’

Professional roles and involvement:

- The Role of the Physiotherapist
    - As perceived by others
    - Early involvement
    - Model of working
    - *The* allocated Physiotherapist
- Role of Occupational Therapist
    - Later involvement
    - Model of working
- Challenges for Physiotherapists
    - Pressure
- Challenges for Occupational Therapists
    - Lack of understanding
    - Challenge to assert role
    - The focus on mobility
- Traditional hierarchies
    - Medicine
    - Physio
- Alliances
    - Physio and medicine
    - Physio and OT
        - Providers of rehab
- Other roles
    - Troubleshooters and gatekeepers
    - Wider MDT

Examples from the data:

Professional roles and involvement

Perception of the physiotherapy role: Fieldnotes p100 “Physio’s have main responsibility for decisions about rehab potential”.

Early involvement: I3 “So we’ll do chest physio, we would still sit them out”.

Model of working: I1: “We’re seeing people every day”

***The* Physiotherapist:** Fieldnotes p142 “But the physio’s who are here today are only covering”.

Pressure felt by physiotherapists: Fieldnotes p196 ‘Clock is ticking’.

Role of Occupational Therapist/Model of working: I2 “I often don’t get involved as much until we’ve almost reached the end of the rehab potential”.

Lack of understanding about the Occupational Therapy role: I4 “just kind of refer to OT as…when people need equipment, or when they don’t really know what people need”

Challenges for Occupational Therapists to assert their role: I5 “I don’t think people look to the OT as much”.

The focus on mobility: I5 “It seems like it’s simmered down to this one thing, and the physiotherapists are the therapists that come to mobilise the patient’.

Hierarchies – I3 “They got overruled by the medical team”

Alliances – Fieldnotes p221 “One of the big things was getting the Consultant’s agreement”

Troubleshooters – I2 “Challenged by one of the discharge team”

Final themes and Sub-themes:

Theme: Professional roles

Sub-themes:

- The traditional hierarchy
- The Physiotherapy role in decision-making
- The Occupational Therapy role in decision-making
- Comparing the Physiotherapy and Occupational Therapy role

7.2. The traditional hierarchy

Before discussing and contrasting occupational therapy and physiotherapy roles, it is important to note that traditional hierarchies within healthcare decision-making were observed. The team on the base ward discussed that the consultant tended to have the final say about transfer to other wards, and bed managers discussed that it was a consultant responsibility to list patients for beds on other wards (despite in reality this happening through nursing staff or ward clerks). When discussing the case noted on page 159, the base ward physiotherapist reflected that ‘one of the big things was getting the consultant’s agreement’ which suggested that this physiotherapist recognised their own opinion would be valued, but only if in accordance with senior medical staff.

Another example to illustrate this was noted during an interaction on the base ward between Patient 4, two family members, the occupational therapist and the social worker. Following the interaction, I discussed with the family members whether they understood what was likely to happen next, with the response ‘we will check with the doctor before we leave tonight’. Although the occupational therapist had discussed plans for discharge and a care package at home, the family perceived the doctor to be the decision-maker in relation to these issues.

7.3. The physiotherapy role

The role of the physiotherapist presented as being significant to the evaluation of rehabilitation potential. In relation to the evaluation of rehabilitation potential, different team members placed importance on the assessment and opinion of the physiotherapist. During a discussion with one of the doctors on the base ward when explaining the focus of the research on understanding decisions about rehabilitation potential he shared that ‘physio’s have the main influence and responsibility…if they think they can improve [a patient’s mobility]’. Another example emerged during an MDT meeting on the base ward, where the base ward physiotherapist was not present and nursing staff raised in relation to a particular patient that they needed to ‘speak to physio’s to find out if he has potential’.

Physiotherapists presented as being aware of the value that the wider MDT placed on their role and their professional judgement, illustrated in interview discussions:

> “I do think we do [have a key role in decision making] which I think is really good…as I keep saying, it is an MDT approach but I think, the focus is often on how are they transferring, how are they mobilising, so then that immediately then comes down to us” (I1, Line 459).

The significance that the team placed on the physiotherapist’s evaluation of rehabilitation potential was then also seen to carry through to the significance the team placed on their recommendation about an appropriate pathway. During an MDT meeting on the base ward (the same meeting above where the physiotherapist was not present) the team discussed whether a particular patient would go home from the ward or go to the rehabilitation ward. The consultant concluded ‘see what physio make of him during this week’. Another example during a base ward MDT meeting involved a direct discussion between the consultant and physiotherapist with the consultant summarising at the end of a discussion ‘we need to liaise with each other…let us know if you think [the intermediate care unit]. In a further example, the occupational therapist asked ‘Shall we list her now [for the rehabilitation unit]?’, with the consultant’s response ‘No…wait until physio see her’, suggesting that the opinion of the physiotherapist was valued above others.

7.3.1. Perceptions of why the role was significant

Physiotherapists in this setting recognised that the public awareness of physiotherapy, and the construction of physiotherapy as the main profession who focus on mobility contributed to the role being seen as integral to rehabilitation and rehabilitation decision-making. However, the physiotherapists discussed that there were other influences on why their role was integral. Within this, they discussed the likelihood of physiotherapy knowing most, if not all, patients (related to blanket referrals) and the likelihood of involvement at an early stage due to their role in acute and medical interventions. This was also noted during fieldwork observations; that physiotherapists contributed to MDT daily handover and weekly meetings with a range of information about different phases of care and with more frequency than occupational therapy.

> "And…it's not until people come in to hospital and see the wider aspects of physio you know, you think about our other roles, putting NIVs on people, doing chest physio all that sort of stuff….So probably that's why they come to us to ask…and just going back to that respect of the professions, when people realise that we have got skills in other areas…that we have a good previous medical history, that we understand what they are socially from…a rehab perspective…And because we've got that underpinning knowledge I think that does add to why people think, oh well actually they kind of know what they're talking about" (I3, Line 623).
>
> "I suppose because we're just a key part of the MDT really aren't we. And we're seeing people…I think if you were to compare us to occupational therapy, we're seeing people every day. And so we get to know people really well. So we're seeing them from the day they come in to the ward and we're seeing them…sometimes more than once a day, several times a day" (I1, Line 466).

7.3.2. Challenges faced by physiotherapists

Although interventions to promote improvements with mobility are clearly within the scope of practice of physiotherapy, the physiotherapists themselves expressed reflections that this in itself was a narrow representation of their role:

> "…the wider team just say physio, yeah, they mobilise people" (I3, Line 43).

And one physiotherapist suggested that they were aware of, and indeed frustrated by this reduced focus, and were trying to attempt to influence this narrative:

> "I think mobility is probably the bulk of our work but I'm trying to push away from that…trying to think more functional…I try to deter people from just saying we mobilise people. We should be actually saying we functionally rehabilitate people" (I3, Line 27).

Physiotherapists also shared insights that this integral role in decision-making can lead to them experiencing pressure. During observations, physiotherapists discussed that other team members would look to them to solve problems that they could potentially solve themselves and on a couple of occasions, used expressions such as 'the clock's ticking' to describe how they felt when the wider team were awaiting positive outcomes from a rehabilitative process.

The further extract below highlights the pressure experienced by physiotherapists linked to expectations of family members:

> "And [a family member] was absolutely livid because he said 'I was told that my mum was coming to this [rehab] unit to get 2 hours of physiotherapy a day…and what's happening…she's not getting anywhere near this" (I1, Line 496).

7.4. The occupational therapy role

7.4.1. Focus on mobility

Occupational therapists did recognise the dominant focus on mobility within the rehabilitative process and how this influenced their own role. In part, they rationalised this through the recognition that mobility was a foundation to improvements and safety in other functional areas (such as dressing and toileting). However, occupational therapists did express finding this particularly challenging:

> “Particularly as we’re OTs it should be around all areas of life but it just doesn’t seem to be that way in hospital, it’s whether people can get up and walk or not” (I5, Line 44).

7.4.2. Role in decision-making

In contrast to physiotherapy, fieldwork observations suggested that occupational therapists were less involved in evaluations of rehabilitation potential and less involved in the decisions about pathways. Similar examples to those above where the physiotherapy opinion was sought to support decisions, were notably absent in relation to occupational therapy. In MDT meetings on the base ward, the occupational therapist was observed to provide feedback on issues such as equipment needs or environmental considerations, although presented as having limited involvement in evaluations of likely improvements, or appropriate pathways. Indeed, it was observed that on some occasions, important decisions were made before occupational therapy became involved with one nurse expressing during an MDT meeting that ‘[a patient is] not going to rehab. Needs OT involvement and a big package of care’.

Occupational therapists were aware of such issues, particularly aware of the impact of their model of working and the limited involvement at an early stage on their involvement in rehabilitation decision-making:

> “I think it’s probably because [the physiotherapists] do have the time to see every patient every day and I don’t. So, they’re going to have more understanding of what they…you know, they’re going to have more an opinion than myself that’s never met someone”(I4, Line 264).

Indeed, perhaps because the occupational therapist had more limited involvement with some patients, there were some understandable examples where they relied on an alliance with the physiotherapist for information or judgements. It was not uncommon for the occupational therapist on the base ward to ask the physiotherapist whether identified patients needed occupational therapy involvement. Also, during a morning handover meeting when there was no physiotherapist present, the occupational therapist provided verbal feedback that ‘physio feels may be plateauing’, and the action agreed was that the occupational therapist would check back with the physiotherapist for further information.

7.4.3. Respect for the occupational therapy role

Interview extracts from occupational therapists indicated that there was a perceived difference between how they understood the importance of their role in relation to rehabilitation and subsequent decision-making and how the role was perceived by others:

> “With the occupational therapy role it’s not as kind of, not respect…I wouldn’t use the word respect…well I guess respected as a physiotherapy input in the MDT. I think sometimes people look to the physios more than they would to the OT in the first instance and what we’re working on” (I4, Line 46).
>
> “we are very much a key player but I don’t think people recognise that. Because I’ve been told that people…you know…they don’t have rehab potential and they just need this piece of equipment. And I think, some of that’s possibly down to people not fully understanding what our role is as well” (I2, Line 643).

Many of these issues presented as being frustrating for occupational therapists, and this frustration and potential need for ongoing assertion of their value and role was communicated through the language used in discussion. One occupational therapist reflected that people didn’t look to them as much for their opinion and that it is her job to “pipe up” with important information. Another occupational therapist discussed being “adamant” that a person would achieve the functional gains she was working towards. Indeed, language almost became suggestive that the ongoing need to assert their value and role sometimes led to positions of confrontation:

> “Well generally if somebody has rehab potential, I would usually be trying to fight to keep them where they are at” (I2, Line 482).

7.5. Comparing the physiotherapy and occupational therapy role in decision-making

An initial area of comparison has already been highlighted, in the sense that physiotherapists tended to become involved with patients at an earlier stage of an admission, and they tended to see patients more frequently than their occupational therapy counterparts. Physiotherapists did not simply get involved earlier and more frequently because they had the capacity to do this or due to a different pattern of working, but that their involvement linked to the treatment of acute medical issues during acute stages. This involvement then translated to knowledge about the majority of patients on the ward at any given time and potentially to professional respect within the wider team.

An occupational therapy participant discussed awareness that medical knowledge and involvement in medical treatment could also account for the significance placed on physiotherapy opinions and decisions, but instead of relating this to professional respect, suggested more candidly that this translated to a perception of power and was rooted in different philosophical foundations:

> “I think physios have more power but I think it goes back to the medical model, social model. Because I think we ascribe more to the social model rather than the medical model, although I would say we have a foot in both camps” (I2, Line 697).

An extract from another interview reflected that, instead of simply assuming that the dominant focus on mobility contributed to the different value placed on occupational therapy and physiotherapy professional opinions, it could indeed be the way occupational therapists work that may have contributed to this dominant focus on mobility and therefore they themselves have inadvertently contributed to hierarchies within the team:

> “It seems like it’s just simmered down to this one thing [mobility], and the physiotherapists are the therapists that come in every day to mobilise with the patient, they are the ones who are looked at to see if they have any potential. Some OTs might see patients when they hit the ward, I don’t do that, I’ll see them a little bit after and then I’ll speak to the physio about rehab potential and get their insight in to it. So maybe we’ve created it a bit…I don’t know…” (I5, Line 316).

Interestingly, as decision-making reached more progressed stages – particularly in relation to decision-making about pathways for discharge home or alternative care environments – the influence of physiotherapy was observed to change and become less significant. It was also observed that increased responsibility was assumed by the occupational therapist in some examples. In relation to Patient 5, the occupational therapist was noted to attend a planning meeting although the physiotherapist did not. During a subsequent discussion, the physiotherapist reflected ‘I didn’t go to the planning meeting yesterday because it wasn’t particularly physio…we haven’t got the staff to go in to every single planning meeting’. But from this, when asked whether physio staff had had input in to the decision about referral to the reablement team, the physiotherapist indicated ‘I haven’t actually…no...because I haven’t really had a chance. But often [the rehabilitation ward OT] will come and say…do you think it would be a good idea if reablement went out and did outdoor mobility and things like that’.

In the case of Patient 2, during a discussion on the rehabilitation ward (approximately 4 weeks after the original acute admission, and approximately 3 weeks after the physiotherapist on the rehabilitation ward first assessed this patient), the physiotherapist reflected that the patient was not making any progress and it was felt the patient did not have further rehabilitation potential. When asked if the physiotherapist had talked to the family about this, the response was ‘No…at this stage I tend to leave that to nursing or social work although I would certainly speak to the family if they asked to’.

The occupational therapist on the base ward demonstrated insight in to the fact that the physiotherapist’s assessment was significant to the evaluation of rehabilitation potential, and perhaps more significant than their own evaluation. This was illustrated during a discussion about Patient 5: ‘I just didn’t think there would be that much potential for him to get better. But obviously, I think [name of physiotherapist] had seen him more than me and felt like could get a little bit better’.

Language utilised to reflect on their own roles was notably different between occupational therapists and physiotherapists. It has been highlighted above that language used by occupational therapists was indicative of challenges to voicing and asserting their role and value, and on occasion this indicated confrontation. In contrast, observations of, and interviews with, physiotherapists suggested a confidence in their professional role. This was captured during one of the interviews:

> “9 times out of 10, in my thinking about sending someone ongoing to somebody else to rehabilitate them then…I would be quite confident in what I was sending them for, and sending them to” (I3, Line 502).

Interestingly, physiotherapists also communicated a need to assert the occupational therapy role and shared attempts to do this on their behalf. One physiotherapist discussed trying to get away from ‘rehab being just about physio…it’s also about OT’.

Despite the differences, it was evident within fieldwork observations and through interviews that there was an allegiance between occupational therapy and physiotherapy. If one was unable to attend a handover or MDT meeting, there were instances where the other would feedback on their behalf or take responsibility to share information afterwards. Similarly, if a different therapist was providing cover (most often due to leave), they would seek out the ward-based occupational therapist or physiotherapist to support their assessments. There were also observed examples where occupational therapists and physiotherapists conducted their own informal handovers, sometimes after the more formal morning handover had finished, which presented as serving the purpose of consolidating information and prioritising daily tasks between the professionals. This observation that occupational therapy and physiotherapy professionals recognised similarities and shared ways of working was expressed during interviews:

> “Between things like occupational therapists and physiotherapists. I think we work along very similar lines” (I1, Line 210).

7.6. Chapter summary

This section illustrates the significance of the physiotherapy role in evaluating rehabilitation potential, in making decisions about rehabilitation pathways, and in the general contribution to, and value within, the acute healthcare team in this context. This was observed and discussed as being influenced by the dominant rehabilitation objective of improving patient mobility (traditionally a central domain of physiotherapists), alongside physiotherapy involvement in acute medical management, and the approach to involvement with every patient.

In contrast, occupational therapists had a less evident role in evaluations of rehabilitation potential and pathway decisions, which they, and others, attributed to not being involved with all patients and generally being involved at later stages. Occupational therapists also recognised that their own practice was being shaped by the dominant focus on mobility in this context. Both of these elements – the value placed on their role and the way the role was being shaped by context – presented as increasing feelings of frustration and challenge for those involved.

CHAPTER EIGHT – DISCUSSION

8.1. Chapter introduction

The research findings presented in chapters four-seven provide an early layer of interpretation, in that I have chosen instances of field observations, vignettes and verbatim extracts to illustrate themes and subthemes. Evident from the presentation of findings are over-arching hypotheses that now become the focus of further analytical discussion.

Firstly, the meaning of rehabilitation in acute care is complex and highly influenced by context, yet it takes on a simplified and reductionist form which often means it gives precedence to organisational rather than patient-centred objectives and is often significantly different to ideals. Secondly, the meaning of rehabilitation potential is ambiguous, not explained to patients, again takes on a reductionist form, but alongside this the concept is evaluated subjectively and becomes synonymous with judgements about movements within the healthcare system. Thirdly, in part because of this overlap between an evaluation of rehabilitation potential and a high-stakes movement within a system, an evaluation of rehabilitation potential carries multi-faceted ethical dimensions about access to, or withholding of, services which contribute to ethical distress for those making decisions and to real-world tensions when working towards sound ethical practice for older people. Finally, physiotherapists are key protagonists when evaluating rehabilitation potential and reaching decisions about rehabilitation pathways which promotes value and esteem for this discipline, although at the same time can be a source of challenge for occupational therapists.

This chapter will firstly present the wider social and cultural context which acts as a backdrop to meaning-making and decision-making for those within the field. According to Bourdieu, to explain any social event or pattern, a writer must closely examine the social constitution of the agents and the makeup of the social universe, including all of the conditions in which they operate (1989; cited in Wacquant, 1998). The chapter will then focus on the four central tenets outlined above to develop further and more critical layers of reflexive interpretation, drawing on multiple sources of knowledge to weave a more holistic web of cultural structures, knowledge and meanings which, superimposed on to one another, form a deeply layered cultural and social script (Seale, 2018).

8.2. The ‘macro’ influences on meanings and social constructions within the acute hospital context

The methodology chapter highlighted that a distinguishing feature of ethnography is the way in which it makes links between daily occurrences and wider social, cultural and political influences (Savage, 2006). An aim of this study was to understand decision-making in relation to rehabilitation potential and rehabilitation pathways and therefore integral to this sense-making is critical analysis of the wider social and political background against which these daily decisions are made.

Although many models of rehabilitation continue to rapidly develop, and often with an emphasis on specialisms, alongside community, long-term, and closer to home models - a multi-faceted, multi-professional rehabilitation phase of care in the context of acute hospital admissions continues to be recognised in current policy and guidance (NHS England, 2016a).

However, whilst rehabilitation based in acute hospitals continues to be recognised, it is important to re-examine the surrounding context in relation to acute admissions for older people. Average length of stay for older people following an emergency admission has decreased in recent years from 12.9 days (in 2010-11) to 11.9 days (in 2014-15), although this has happened at the same time as a growth in the number of older people experiencing an emergency admission to hospital (increasing by 18% between 2010/11-2014/15) and overall bed days from such admissions increasing by 9% in the same period (Department of Health, 2016). Simply put, there are more of this population in hospital, but their individual length of stay is shorter. Simultaneously, and significantly, there has been a well-communicated projected ‘funding gap’ and necessary efficiency savings (NHS England, 2014b). Services which require time and interventions of high frequency, whilst experiencing high demand, will inevitably be under pressure.

Acute hospitals are increasingly organised around common clinical conditions and anatomical systems and this was clearly evident within this site. Stroke units, coronary care units, and dedicated orthopaedic wards are all common specialisms within acute hospitals, with larger sites often hosting other regional specialisms for areas such as oncology, major trauma and paediatrics. The alignment with a biomedical model of health is recognised as an overriding framework – that is to say, systems and pathways organised around a clinical condition (such as a fractured neck of femur) or an anatomical system (such as cardiology). This overriding paradigm of a biomedical model of health at a macro level is important to note and is another element of the backdrop against which professional thinking and decision-making was set.

It is important to acknowledge that the organisation of healthcare systems and specialisms aligned with clinical conditions is based on sound evidence. Where teams and services orientate environments and expertise to common presenting needs, and the more experienced they become in managing these needs, evidence supports better outcomes for patients (NICE, 2016b; Stroke Unit Trialists’ Collaboration, 2017; Smith et al, 2015). However, it is also here where a critical paradox emerges for those with a non-uniform presentation of disability not easily categorised by one condition – notably the older and frail population who were the main users of the base ward at the centre of this study. Despite being the largest users of health and care services, a picture begins to emerge of a system which is orientated away from their needs and struggles to identify the most appropriate services and locations (Bail and Grealish, 2016). Examples from fieldwork where patients were moved within the system because of a perception that services did not know what to do with them, or because they required a general or vague ‘sort out’ are indicative of this challenge.

It is perhaps influenced by this trend of specialisms attracting resources and profile that rehabilitation itself has also attempted to become a specialism. Specialist societies of rehabilitation medicine such as the British Society of Rehabilitation Medicine (BSRM, 2017), scholarly journals and specialist commissioning guidance (NHS England, 2016a) all allude to this specialism. The organisation of the system during the first period of fieldwork, with a separate ward for rehabilitation was reflective of this. However, Wade (2016) highlights a critical challenge that has emerged from this – that rehabilitation as a separate specialism carries an implicit assumption that patients receive rehabilitation *or* medical care, with the manifestation of this being that patients physically move locations between medical services and rehabilitation services. This was particularly evident within the study context where rehabilitation was associated with place, and that a move to this place was associated with the commencement of a rehabilitative phase of care. Wade goes on to suggest that this intrinsically carries risks – such as rehabilitation or medical care being absent of lesser priority when the patient is in the boundaries of the alternative service; it can lead to disagreements over responsibility; and lead to reduced efficiency due to duplication or gaps in interventions or communication (2016).

It was not only in the organisation of the hospital system where a biomedical model of health was evident. Notably, the focus on rehabilitation to bring about improvements in physical abilities, and more specifically mobility, emerged as a significant way in which rehabilitation was constructed. Social theorists have long recognised: the value of bestowing social power according to body and physique; that the body is a marker of social class and; bodily function signifies worth (Hammell, 2006; Bourdieu, 1984). Alongside this, a historical perspective of physical rehabilitation supports an emergence from medicine and surgery at the time of World War 1 (Linker, 2016), and the quote from a phase 3 interview suggesting rehabilitation is perceived as a ‘getting soldiers to walk again type of place’ emphasises that this historical perspective still rings true.

8.3. The meaning of rehabilitation

8.3.1. Revisiting definitions of rehabilitation

As outlined in the background to this project, definitions of rehabilitation are wide and varied, particularly when the word is attached to particular contexts or specialisms. Extracts presented in Table 11 highlight the understandings from study participants of what rehabilitation is and what it is not, and enable comparison to both lay and professional definitions. Notably, what rehabilitation means to professionals in this setting bears close resemblance to lay definitions, although extracts from discussions about what they would like rehabilitation to be suggest aspirations towards a more multi-dimensional version, more reflective of professional definitions and ideologies. Findings also indicate other layers to the meaning of rehabilitation which are not necessarily verbalised in participant definitions, but instead are communicated in the versions of rehabilitation which are enacted in practice.

Table 11: Definitions of rehabilitation

Examples from study participants – what rehabilitation is…	**Examples from study participants – what their version of rehabilitation is not…**	**Example lay definitions**	**Example professional definitions**
"getting back something that they've lost" "getting them back to that level of function that they were previously at"	"I think we all want this text book thing…you know, goal-led, get the carers, get the family members, get the patient, do it all together. But it's not always as easy as that" "the way I look at rehabilitation is having time to work with something…somebody…on some meaningful activity. Say it's…washing and dressing for example, if someone can't manage that. It's working with them daily, having daily input with that person, practicing tasks, so that they can…possibly become independent or improve in their independence in that area that we're looking at. But that relies on having the time to do that"	The action of restoring something that has been damaged to its former condition (Oxford English Dictionary, 2017) The process of returning something to a good condition (Cambridge Dictionary, 2017)	A health strategy that aims to enable people with health conditions experiencing or likely to experience disability to achieve optimal functioning in interaction with the environment. (WHO, 2001). A complex process which enables individuals after impairment by illness or injury to regain as far as possible control over their own lives (Kings Fund, 2001).

8.3.2. A version of rehabilitation that values (physical) improvement

The extracts in Table 11 suggest that, at a foundation level, professional's associate rehabilitation with facilitating improvement. Furthermore, findings highlight that in this context, rather than rehabilitation being a 'black-box' with multiple ingredients to bring about physical, social, emotional and environmental improvements, more realistically rehabilitation was often characterised by a one-dimensional ingredient of improving mobility. The influence of social theory discussed above which places value on physical strength, and of a biomedical model associated with treating a bodily impairment to restore it to a former condition, are significant. Professional perspectives (represented strongly within data) and patient perspectives (represented less strongly but with important insight) both conceptualised rehabilitation as a process to improve bodily strength and function.

Hammell (2006) recognises that the aim to enhance physical function has become a preoccupation for rehabilitation professionals although suggests this is inadequate for people with deteriorating or chronic conditions where remediation of physical function may be an insufficient or unrealistic goal. Furthermore, research suggests that older adults themselves feel that rehabilitation in acute settings is not meeting their holistic needs (Atwal et al, 2007). In this setting, professionals recognised that they had limited time to address wider functional, psychological, and social needs and were being driven to focus on needs that would quickly influence safety for discharge. Attempts to meet wider occupational needs (‘can we not just get a carer [for bed transfers]’ – page 143) or social and psychological needs (‘nice to do…but not realistic’ – page 139) were out of alignment with the way of working.

8.3.3. A version of rehabilitation that values flow and efficiency

A key implication of much of the background context about hospital admissions and length of stay is that, for practitioners delivering care and treatment in the acute context, this arguably contributed to a value on fast-paced trajectories maintaining efficient flow within the system. This view is suggested within the research findings and reported in other published studies (Bail & Grealish, 2016). The example on page 159 where the physiotherapist reflected a change in reasoning to prioritise those they could move on more quickly, rather than those who required more intensive therapy illuminated this issue. Indeed, to develop this further, authors have suggested that is it not only the progressive changes to demographics and usage, but also the application of neo-liberal principles to health care systems, where the focus has shifted from quality of care towards attaining performance standards in relation to risks and efficiencies, which is directly influencing the thinking and reasoning of health professionals (Durocher et al, 2016). The emergence of a tension between rehabilitation as a process which requires time for collaboration and learning to optimise improvements, and rehabilitation as part of an acute care system is obvious.

Alongside frequent discussions about time pressures, professionals were also aware of the significance of the measurement of length of stay, with ‘length of stay meetings’ used to publicly report this outcome, and examples where a large set of notes (page 159) was seen as a negative indicator of a patient’s progress or the ward being reflected in a negative light.

8.3.4. A version of rehabilitation that prioritises optimum safety rather than optimum function

The threshold aim for rehabilitation for the institution was becoming safety for discharge, rather than optimum improvement towards baseline function (which had been part of the narrative during phases 1 and 2 of fieldwork). This was communicated strongly during phase 3 interviews in relation to how the organisational hierarchy wanted to discourage use of the word ‘baseline’ (which had been observed to be an embedded part of a shared language), and therefore discourage professionals from using a patient’s previous baseline as the aim of any rehabilitative interventions. This not only meant that optimum safety superseded optimum function as the primary aim of rehabilitative interventions, but also meant goals of aiming to address the broader fundamental principles of rehabilitation of increasing physical, social, psychological and emotional wellbeing implied in their own discussions (Table 11) and professional frameworks (WHO, 2001; WHO, 2017) were becoming further removed from real-world practice.

This challenge of not being able to focus on wider facets of rehabilitation was noticeable during observations (for example professionals felt that they could not give priority to interventions which focussed on improving mood or social interaction), and the narrative shared during phase 3 interviews suggested this had only grown in significance. Interestingly, this is perhaps another example of the influence of the biomedical model of illness, where body and mind are considered separately (Wade and Halligan, 2017).

Professionals recognised that optimum safety in wider activities of daily living is often linked to improvements in mobility (page 138) and therefore the value placed on physical improvement and working towards safety could be interpreted as part of the same overall values of rehabilitation. However safety can often be achieved earlier in a rehabilitation process than optimum function (through strategies such as environmental modification and carer support) and therefore this focus on safety was assisting the organisation to shorten length of stay and free up beds and resources to meet increasing demands. Statistics presented at the beginning of this chapter illustrating shorter hospital admissions despite increasing demand (Department of Health, 2016), and examples which suggest inpatient rehabilitation is being reduced to a process of ‘destination triage’ (Durocher, Gibson and Rappolt, 2016), suggest that this is a reality not just in this local context, but at a national and international level.

An additional area of challenge was that to facilitate discharge at an earlier stage and a lower functional level, professionals needed confidence in community services to address ongoing rehabilitation needs, and this was something that was of real concern (pages 143; 150).

8.3.5. A version of rehabilitation happening in a separate place

The influence of rehabilitation being conceptualised as a separate specialism could also be understood to be shaping the construct of rehabilitation in this acute hospital setting. The strong narrative of rehabilitation as a place and as happening outside of the base ward was illuminated through direct fieldwork experiences and participant quotes. This had far-reaching implications for both professionals and patients: professionals discussed that patients could be ‘bounced back’ to the base ward (often from the intermediate care unit) if medical needs were deemed to be difficult to manage; professional assessments recommenced with different professionals on arrival to the rehabilitation ward often resulting in duplication; and patients could become less of a priority for physiotherapy and occupational therapy whilst on the base ward because they were waiting for a transfer to the rehabilitation ward.

Another implication for professionals was that, if rehabilitation was seen as a separate specialism existing in a separate location, then it was therefore not being provided on the base ward. The occupational therapists and physiotherapists delivering services on the base ward - professionals, who traditionally are accepted as core providers of rehabilitation and associate their professional identity with this (Colquhoun, et al 2016; Atwal et al, 2007) - indicated discomfort and tension with this. This was yet another source of the frustrations and ethical challenge facing these professionals.

It is therefore an interesting point to note that the rehabilitation ward was renamed and reconfigured during the period between phase 2 and 3, with professionals discussing in interviews that part of the rationale for this was the integration and co-location of a rehabilitative phase of care with medical care and management. This notion is supported by Wade (2016) who presented risks and critique of rehabilitation claiming specialisation in its own right. And although in relation to the specialism of stroke, the co-location of acute and rehabilitation services was found to be equally as effective in improving functional outcomes as traditionally separately located services and more efficient in terms of hospital bed utilisation by reducing some of the challenges and duplications associated with waiting times and internal transfers (Chan et al, 2014).

Although the local site within this study was reportedly moving towards this model for older people's services, a separate off-site rehabilitation unit (which although not like-for-like, was a replacement of the previous intermediate care unit) was still in existence which meant risks and problems associated with rehabilitation in a separate location could also still present potential issues. It was beyond the parameters of this current study to explore these changes in more detail.

8.3.6. A perceived gap between ideal and real-world versions of rehabilitation

With pressures on the front end of the system, alongside less beds for the purpose of rehabilitation, and coupled with an organisation influencing staff to prioritise transfers of care and discharge, it is not surprising that professionals described a gap between ideals of rehabilitation and their perceptions of the realities of service provision. Importantly, the value on fast-paced trajectories and prioritising safety led to compromises in terms of time available, consideration of holistic needs, and meaningful patient involvement – all seen as desirable and best practice features of rehabilitation, but expressed as being impossible to deliver in reality.

A multi-professional approach is highlighted in literature and policy (Wade, 2015; Wade 2005; Whyte, 2009; WHO, 2017) as a best practice feature of rehabilitation and one where the realities of service provision may have also been perceived to be falling short. Although a multi-disciplinary approach was evident (in the sense that doctors, nurses, therapists and social workers, among others, all contributed to rehabilitation and decision-making at different times), a uni-disciplinary paradigm was implied in that the physiotherapy role was implicitly and sometimes explicitly acknowledged as the main protagonist in a phase of care associated with rehabilitation. Equally, the lack of multi-professional representation within the community reablement team resulted in a struggle for professionals to fully conceptualise this team as a provider of rehabilitation.

Because of the many layers of disparity between ideals and realities, links can be made between concepts which acknowledge disconnection between workers and the outputs of their labour: for example the Marxist theory of labour alienation (Marx, 1844; cited in Durocher et al, 2016) which purports that individuals may experience alienation if their employment does not afford the control, decision-making or creativity they desire from the role. Polatajko et al (2007) echo such sentiments in more recent work by discussing that occupational alienation may occur if external forces result in occupational roles that no longer fit the individual's potential or aspirations. An increasing awareness of systemic external pressures in relation to resources, coupled with discussions which implied a difference between a desired model of rehabilitation and the reality of what could be provided in practice were clearly observed within this research and highlight a real and ongoing challenge facing a rehabilitation workforce in the context of acute care.

To summarise this section, Figure 12 presents the main ways in which the concept of rehabilitation was observed and interpreted from the research findings. Although this representation does not perhaps do justice to some of the complexities relating to, and emerging from this issue, it does provide an at-a-glance insight in to some of the main challenges to patients, families and professionals of such conceptualisations and provides insight in to a contemporary and real rehabilitation taxonomy present within discourse and practice.

Figure 12: A taxonomy for rehabilitation in the acute hospital context

REHABILITATION AS…		
Example	**Main Influences**	**Main Risks**
IMPROVEMENT	Desire for positive change	May not be realistic for frail older people
PHYSICAL IMPROVEMENT	Physiotherapist as main protagonist Value on bodily strength and function	May not be realistic for frail older people May not attend to wider aspects of emotional, social, spiritual functioning
PHYSIOTHERAPY	Physiotherapist as main protagonist Later and less frequent involvement of Occupational Therapy (and potentially other rehabilitation professionals)	High expectations of (and pressure on) the physiotherapist from patients, families and other professionals Low involvement/value of other professionals
PLACE	Association that different wards and units would have more time/staff/facilities	High expectations of the identified place from patients, families and professionals Provision of rehabilitation equated with a desirable move within a system
TIME	Gold standard of rehabilitation associated with time intensive activities (such as goal setting, family involvement and opportunities for learning)	Incongruent with time pressures of acute care
NOT HAPPENING/IDEAL	Many discrepancies between ideals and realities of rehabilitation	Not meeting expectations (leading to dissatisfaction, distress, alienation) of patients, families and professionals

8.4. The meaning of rehabilitation potential

8.4.1. The ambiguous nature of rehabilitation potential

The initial review of literature, mainly related to the concept of rehabilitation potential following stroke, highlighted rehabilitation potential as an ambiguous concept and this lack of clarity has been extended within this current study to judgements relating to rehabilitation potential of older people following an acute hospital admission. Even if the findings simply hold a mirror to this issue for professionals who regularly use the term in their professional practice and encourages a more detailed articulation of meaning, this is an important development. The simple yet critical question of ‘potential for what?’ highlighted by one professional in the field crystallised some of the many challenges with this ambiguous term.

8.4.2 Potential to improve

The findings presented in section 6.3.4 highlight that, linked to the concept of rehabilitation being conceptualised as a process to facilitate improvement, it followed that rehabilitation potential was conceptualised as the potential to make improvements through engagement with a period of rehabilitative interventions. Once again, a narrow and reductionist worldview is evident which does not fully acknowledge rehabilitation as something which can optimise and maintain function through adaptation and learning. This narrative could contribute to practices where patients who are unlikely to improve physically, but could make quality of life gains through compensation, adaptation and learning, are deemed to have limited rehabilitation potential with rehabilitation resources subsequently withheld.

8.4.3. A blurring of rehabilitation potential and an internal transfer

Lane et al (2017) discuss that the concept of potential benefit is an important criterion when considering resource allocation and pathway decisions, something which was uncovered in this study. Such judgements reflect high-stakes outcomes for individual patients, leading to the allocation of a bed, or the access to (or withholding of) an intervention. Indeed, the National Audit Office’s review of the National Stroke Strategy (2010) reported that 30% of stroke units excluded patients for a bed on the basis of ‘no rehabilitation potential’, a practice described as unacceptable.

This clearly emerged from the research findings; that a judgement about rehabilitation potential almost became synonymous with a judgement about the appropriateness for an internal transfer of care. That is to say, a positive evaluation of rehabilitation potential often accompanied a judgement about transfer to, or maintenance within, a bed in a rehabilitation environment. And conversely, a negative evaluation of rehabilitation potential often equated to judgements involved in ending the episode of inpatient or bed-based care or to question the appropriateness of onward referral to a rehabilitation service. This also links with practitioners connecting a positive evaluation of rehabilitation potential with giving people a chance, and conversely the label of limited rehabilitation potential recognised as often linked to denying services and potentially doing harm (Enderby et al, 2017). It was perhaps here that the ambiguous, interpretive nature of the concept of evaluating rehabilitation potential was open to potential manoeuvring by professionals with subsequent high stakes decisions for patients and ethical tensions for professionals.

Whilst recognising that internal transfers are an important part of bed-based care in a modern hospital system (Bail and Grealish, 2016), it is the entwined nature of an internal transfer with a positive evaluation of rehabilitation potential which poses critical challenges. This was most acutely emphasised by staff on the rehabilitation ward and intermediate care unit discussing that they often received people identified as having ‘rehabilitation potential’ although their own perception was that they received patients that other services ‘don’t know what to do with’.

This implied shifting of responsibility within hospital systems has been recognised in other studies (Dodier and Camus, 1997). One reason it was perhaps particularly pertinent in the environment at the centre of this this study was that individual wards were required to report their own length of stay. It was implied by health professionals that if a positive evaluation of rehabilitation potential increased the likelihood of a transfer to a rehabilitation bed, this positive evaluation also resulted in a positive outcome for the ward in terms of managing length of stay and promoting flow. Changes to reporting length of stay, such as evaluating a so-called ‘superspell’ – an overall length of stay across hospitals and other bed-based providers (Chalk & Pitt, 2015) - or more fundamental review of the necessity to report in this way at all, could reduce the desire to move patients who are viewed as problematic.

But it is the implications for the patient and family which are of equal, if not greater, significance. When communicated to patients and families (and this in itself cannot be assumed to have been routine practice as it was often not observed or not documented), transfers to the rehabilitation ward or intermediate care unit were discussed in relation to likelihood to make functional improvements (‘to get stronger’ – Patient 5). Professionals reflected that transfers to rehabilitation environments were ‘sold’ to patients and families in terms of time intensive interventions and better facilities (page 147), and yet resources suggested this would be an unlikely reality. The more realistic motivations of moving patients to a less acute bed to afford time to resolve wider issues of risk and complexity were not observed as being articulated to patients in a transparent way. Critical voices have suggested that this represents an allegiance with employers rather than patients and being resource- and target-driven rather than needs led (Hammell, 2007).

Current thinking suggests that if acute and rehabilitation services are co-located and a rehabilitation phase begins on day 1 alongside any curative and supportive phases of care, then the judgement about potential becomes less significant (Chan et al, 2014) and in this case, less tethered to some of the wider influences on reasoning which are linked to a transfer of care. This principle could be recognised in some of the strategic decisions which took place in this study site, with professionals recognising that the change of function of the rehabilitation ward was in part to negate the need for unnecessary hospital transfers and that instead rehabilitation would be co-located with acute care in existing acute wards.

8.4.4. The subjective nature of judgements about rehabilitation potential

Findings that an evaluation of rehabilitation potential is influenced by an interplay of patient-related and system-related factors which are context-specific and open to subjective interpretation is not surprising and this study focussing on a heterogeneous population of older people supports themes which are reflective of other acute specialisms. Important patient-related influences on reasoning in this context included previous level of (or baseline) function, presence of co-morbidities, and cognitive function. In terms of organisational factors, the availability of rehabilitation beds and services also influenced practitioner reasoning about rehabilitation potential and pathways. The fact that baseline information was not always clearly communicated or documented (illustrated in Table 7), and that different professionals interpreted baseline differently (example on page 166) suggests that an evaluation of rehabilitation potential reliant on this information is fundamentally compromised, and is one of many areas where subjectivity begins to emerge.

In their study to explore dimensions of evaluating rehabilitation potential amongst professionals working in stroke rehabilitation, Burton et al (2015) suggest that assessment tools are deemed insensitive to rehabilitation potential, which perhaps helps to explain why assessment tools or structured criteria were not used to assist in the evaluation of potential in this current study. However, this practice is potentially perpetuating subjectivity, contributing to tensions and leaving such important judgements open to the influence of a wide range of clinical and non-clinical ‘noise’ (Enderby et al, 2017).

With professionals attempting to assess and evaluate something which is inherently subjective and imprecise, an awareness that this can facilitate or withhold access to important services which could hold the key to ongoing improvements, and an understanding of cost and resource implications scrutinised by public reporting, it is unsurprising that professionals experienced pressure. It could be hypothesised that the judgement itself could be influenced by the extent of pressure professionals were feeling at different times and from different directions, introducing another area of subjectivity. Pressure from vocal families, pressures during high demand for beds, or pressures due to low staffing were all examples noted during fieldwork. Burton et al (2015) discuss that judgements about rehabilitation potential carry an emotional labour and require emotional resilience which leads to the next section of this discussion about the ethical realities of evaluating rehabilitation potential and the strategies professionals used to meet competing demands of their role.

8.5. The ethical realities of rehabilitation decision-making

Patient related factors such as age, comorbidities, cognitive ability and pre-and post-admission functional status were all theorised within the literature review as influencing practitioner reasoning. However, broader ethical dimensions were found to be influencing and permeating practitioner reasoning. This emerged as an important and less anticipated theme and will therefore receive emphasis within this next section of interpretive and critical discussion.

8.5.1. Real-world application of ethical principles and frameworks

Discussion of deontological and utilitarian ethical frameworks were developed in the literature review (section 2.4.1), with the former being driven by the intention to do good for all, and the latter aiming to produce the greatest good for the greatest number. The desire that everyone deserved a chance at rehabilitation was a frequently shared view, suggesting that the desire to do good for all was an overriding value. However, ways of working often were driven by utilitarian principles – for example not listing people for weekend therapy because of an awareness of others who were more in need and occupational therapy not accepting referrals for patients already residing in residential and nursing care because of higher priority patients and perceived limitations in what could be achieved.

Because resources are increasingly prominent within public discourse in relation to health services, it follows that health professionals are therefore also increasingly aware of this and feel obligated towards a more utilitarian way of working (Garbutt & Davies, 2011). This push and pull between deontological and utilitarian principles is interesting although not remarkable, and indeed has been commented on by other authors (Levack, 2009). Insights shared by professionals within this study that it is the resources ‘that win’, and ‘it all comes down to money and resources’ suggests utilitarian principles are dominating this debate on the ground. This is echoed in other studies where non-clinical factors such as resources and time, as opposed to clinical factors based on need, are more dominant in professional decision-making (Kimmel et al, 2017). It is likely that this once more places pressure on professionals, potentially asking them to put aside their commitments to individual patients and their duty of care, an issue strongly suggested by professionals (page 192) and supported by wider research (Blackmer, 2000).

When considering rehabilitation as a wider concept, it could be proposed that utilitarian principles influence why rehabilitation may attract a relatively low profile and fewer resources. That is to say, evaluation at a macro-level may suggest that the benefits are not justified in terms of the outcomes achieved or the numbers they are achieved for. This is perhaps particularly significant for rehabilitation of an older, frail population where the evidence is not strong and any perceived pay-off is unlikely to reap long term benefits when set against the potential assumptions about remaining expected life, or quality of life (Wade, 2015; Levack, 2009). Also, because these benefits may not obviously accrue to health services (Wade, 2015), due in part to a lack of integration in health and social care, there may be a lack of motivation from decision-makers to invest in rehabilitation for older people. Again, although some of this wider macro context was beyond the reach of this project, it is unavoidable to ignore the reduction of rehabilitation beds during the period of fieldwork and how such organisational influences may weigh on the reasoning of practitioners.

Chapter six presented analysis of ethical dimensions influencing professional reasoning and cited examples linked to doing good, avoiding harm, involving patients and families and promoting fairness. It is here that a frequently cited ethical framework emerges as significant – that of the ‘four principles’ outlined in the seminal work of Beauchamp and Childress (1989) and defended and developed extensively by Gillon (1994; 1995; 2003; 2015). This model suggested that the four principles of respecting autonomy, beneficence, non-maleficence and justice provide a “simple, accessible and culturally neutral approach to thinking about ethical issues in health care” (Gillon, 1994; p184). In simple terms, this model encourages health professionals to consider and balance respect for autonomy and choice of the individuals they serve whilst aiming to maximise net benefit when balanced against minimising risk, and acting on the basis of human rights and fairness, particularly when there may be competing claims for resources.

Perhaps almost on par with the wide citation and application of these principles in practice, research and policy over several decades, has been a strong and often vehement critique. Commentators suggest that the principles merely represent a checklist rather than reflective or analytical guidance for ethical dilemmas or situations of conflict between principles (Clouser and Gert, 1990). Seedhouse further suggests that each broad heading is open for such wide interpretation that the principles themselves subsequently lack meaning (2017). Theorists also propose that the model continues to reflect a paternalistic approach to healthcare with professionals as experts and decision-makers and that the principles do not reflect critical challenges such as making decisions for sustainable healthcare (Hugman, 2005).

It is the extent to which these four principles continue to pervade contemporary practice, debate and, research – including work to critique and contest – that informs the application to the next section of this discussion. These principles are also applied in recognition that they underpin professional codes of conduct (Edwards et al, 2011). However, to represent the critique of this framework, I will ask critical questions throughout with the aim of developing layers of reflective enquiry, challenging simplistic representations and taken for granted perceptions.

8.5.2. Autonomy

Despite a shift in rhetoric and emphasis towards patient-centred practices in healthcare, professionally-led decision-making processes continue to be reported (Leach et al, 2010; Sugavanam et al, 2013). Observations and interviews suggested that the rehabilitation process was not explicitly centred around patient goals, and where implicit goals were set, this tended to be a professionally-led activity. There was an absence of patient and family input in to weekly multi-disciplinary meetings and a lack of focus on, or responsibility for, advocating for the patient at these meetings in their absence. Alongside this, ad-hoc use of family planning meetings, unclear methods of involving patients and families, and unclear processes for gaining consent for onward referrals were all suggestive of professionally controlled decision-making processes.

There are well-recognised challenges to meaningful involvement and engagement for older people and for people within acute hospital systems and authors caution against a ‘one-size’ approach to promoting engagement and involvement (Bright et al, 2015). In particular, many of the features of more patient-orientated goal setting processes – such as building trust and rapport, answering questions, and discussing concerns, priorities and wishes (D’Cruz et al, 2016) – are time intensive activities and practitioners in this setting discussed that these are activities which may be rationed when facing time and resource pressures. However, rather than simply accepting the deficiencies in, and challenges to, current practice there are some practical strategies which could assist, including the use of specific goal-setting forms or tools, which have been found to enhance patient and family engagement (Rosewilliam, Roskell & Pandyan, 2011). And indeed, the 4-stage model presented in Figure 5 could provide a framework to assist with patient and family discussions, assisting to translate what is sometimes an implicit reasoning process, in to explicit dialogue which can be communicated both verbally and in writing.

8.5.3. Beneficence

8.5.3.1. Is there an evidence base that rehabilitation brings about improvement?

Professionals and patients expressed a fundamental belief that rehabilitation was a process that facilitated improvement. Furthermore, the value that a positive evaluation of rehabilitation potential and access to a rehabilitative phase of care would create the conditions to optimise the likelihood of positive outcomes, were values that were evident throughout fieldwork. Therefore, the intention of professionals to bring about a positive outcome through rehabilitation was clear.

Research findings pertaining to the many models of rehabilitation for older people were synthesised in the literature review and, despite many challenges to transferability, an overriding theme emerged that an organised rehabilitative phase of care following a hospital admission for an older person does result in improved outcomes. Therefore, the professional value obvious during fieldwork that a phase of rehabilitation could potentially lead to positive outcomes was broadly supported by evidence. Interestingly however, there were no instances where practitioners themselves made direct reference to evidence during the period of fieldwork.

Returning to issues first illuminated in the literature review, practitioners face many challenges when attempting to look beyond headline general findings, to interpret in more detail the optimum conditions for rehabilitation for older people. Variances in national and international service provision (including the variance in comparisons to usual care and variances in funding), the poor descriptions of what constitutes rehabilitation services, the lack of statistical significance for both positive and negative outcomes, and the inherent challenges relating to the heterogeneous population are all widely reported in relation to the quality of the evidence base. This shines a light on the significant issues faced by researchers, strategists, policy-makers but most importantly practitioners, when aiming to grow, and learn from, a high quality evidence base to support decisions about rehabilitation for older people following an acute admission.

However, research supporting positive outcomes from rehabilitation related to particular specialisms is strong, for example in Stroke, Major Trauma, Spinal Cord Injury and Chronic Obstructive Pulmonary Disease to name only a few. In reality, policy makers present as strengthening a limited evidence base for rehabilitation outcomes for generalist pathways for older people, by generalising from a strong evidence base for specialisms (which by default are likely to *include* older people) and by implication, asking practitioners to do the same. This raises important insights for critical reflection and implications for further research. All of these insights may offer an explanation as to why practitioners did not explicitly make links to evidence during fieldwork observations, with limited confidence or limited understanding potentially realistic consequences of evidence that is challenging to navigate.

8.5.3.2. Beneficence - were ‘good’ functional outcomes evident during ‘patient-tracking’?

Guidelines and evidence provide broad support for practitioner intentions to facilitate positive outcomes through periods of bed-based rehabilitation. However, the narratives of patient journeys tracked during fieldwork (summarised in Table 8) suggest that periods of rehabilitation in these cases (either as part of an episode of care on the base ward or through a joint episode on the base ward and the rehabilitation ward) failed to bring about functional improvements for most patients. It is a reality of health service provision that older people are at high risk of death and functional decline during or shortly after an unplanned hospital admission (NHS Digital, 2016; Milton-Wildey & O’Brien, 2010). The many reasons for admission, coupled with the likelihood of co-morbid health conditions and a life-stage often characterised by frailty and susceptibility to further decline, means that older people can have worse function at the end of a hospital admission than they did prior to admission (Covinsky et al, 2003).

‘Failure to Rescue’, referring to the death of a hospital patient after a treatable complication (Silber et al, 1992) and ‘Failure to Maintain’, referring to the functional decline of a hospital patient following failure to prevent avoidable complications (Bail and Grealish, 2016) are two concepts used to describe and explore failings in acute hospital systems; the former with an international evidence base which has contributed to drivers to improve the recognition of the physiologically deteriorating patient (Massey, Chaboyer and Anderson, 2017). ‘Failure to Improve’ may also be a controversial reality of rehabilitation within acute hospital systems, referring to a lack of improvement towards expected functional goals. This poses yet another philosophical challenge to those professionals who see the facilitation of improvement as an integral part of their role.

There are examples of studies attempting to identify which patients are most at risk of functional decline and mortality during a period of inpatient rehabilitation. Evidence suggests that the use of a comprehensive and valid frailty index with values given to co-morbidities, number of medications, dependence in activities of daily living, cognition and deficits such as previous falls (among other items) can help to predict quality of patient outcome and mortality (Singh et al, 2012). Interestingly, the explicit use of a frailty assessment was not observed within this setting.

8.5.3.3. Balancing beneficence with non-maleficence

As discussed in section 6.2, the evaluation of rehabilitation potential was frequently discussed alongside a desire to give people ‘a chance’ and this word provides important insight in to the probabilities and uncertainties that professionals were contemplating. Indeed, the word itself conjures images of a professional gamble. It was also a reflection of the researcher that the word chance was again indicative of ambiguity: that professionals used the word in the context of their desire to give people the opportunity of a positive outcome but that they often did not know what this positive outcome would mean in reality. Linked to this, the comparison between evaluating rehabilitation potential and a guessing game has been the focus of recent professional discourse (Enderby et al, 2017).

Fieldwork highlighted that a positive evaluation of rehabilitation potential and giving people ‘a chance’ often equated to a longer stay in bed-based services. Professional discourse suggests that, in this respect, practitioners err on the side of ‘beneficent interventionism’ (Singh et al, 2012; p245). However, practitioner reflections and researcher observations (particularly from patient tracking during phase 2) suggested that this may carry risks such as secondary medical complications (for example infections), functional decline, psychological deterioration, and even death. Indeed, the risk of becoming a lower priority for rehabilitation interventions, due to being located in a medical bed but whilst waiting for a rehabilitation bed was also noted during patient tracking and is a risk which has been expressed within published commentary on this subject (Wade, 2016).

Wade (2009) acknowledges wider risks associated with rehabilitation and rehabilitation decision-making. These include risks to the individual of investigating what people can and cannot do and therefore bringing attention to weaknesses and failures; loss of motivation or raising expectations if goals are not relevant or not attainable; rehabilitation inducing passivity; and communicating rehabilitation decisions (such as the decision to stop active therapy) in an ineffective way. Elements of all of these issues were observed or discussed during fieldwork: a patient being transferred to the rehabilitation ward with family having unrealistic expectations (page 147); patients associating rehabilitation with wanting more professionally-led therapy rather than interpreting it as a phase where they can help themselves (page 142); and limited communication about the decision to discontinue physiotherapy (page 181).

Another risk, although one which is hard to quantify and articulate, is the general risk to quality of life of spending an increased proportion of remaining life in a bed-based phase of care. The extent to which honest dialogue took place to enable patients in this context to decide whether this opportunity was worth ‘a chance’ is explored in the section below and related to the concept of autonomy.

If a positive evaluation of rehabilitation potential most often equated to additional time within a bed-based rehabilitation service, one additional outcome worthy consideration is patient experience of such services. Indeed, if patient experience is positive, this can contribute to the achievement of good outcomes, although if negative, this could represent an additional area of risk or potential harm. Unfortunately, due to the limited direct insights gained from patients and relatives in this study (and that this was not a primary area of focus for this research), inferences from this study cannot be made. However, patient experiences of bed-based rehabilitation reported in wider research suggest that rehabilitation may not adequately meet needs or promote independence, there is a lack of involvement in goal setting and that information giving about the purpose of the service is inconsistent (Ariss, 2014; Atwal et al, 2007). It is not within the scope of this current study to suggest whether these themes reflected the patient experience in this local site. However, it is important to note that negative experiences may represent an additional risk which merits consideration when aiming to achieve an important balance between maximising positive outcomes and minimising harm.

If improvements and positive outcomes cannot be assumed following a period of bed-based care for an older person, questions about adverse outcomes must also be examined, although the evidence discussing adverse events and harms is minimal (Wade, 2009). Wade (2009) suggests that one reason for this is that practitioners are not routinely measuring or documenting harms associated with rehabilitation and rehabilitation decision-making, and similarly researchers are not routinely focussing on this within rehabilitation research.

Within the base ward, although the ward was seen to be measuring and reporting adverse events and harms in line with national drivers (NHS England, 2016b), this was generic in nature, measuring one-off events such as falls or infections. Ways of measuring and documenting general functional decline were not explicit, nor was it easy to understand how some of the softer examples of harm (such as raised expectations) were being examined or understood. However, on critical consideration of her own research aims, it must be acknowledged that adverse outcomes or harms were not an explicit focus (within research objectives and therefore not the focus of observations of interviews). It could be suggested that here the social construction of rehabilitation as a process linked to improvement was influencing her own research worldview.

8.5.3.4. Balancing beneficence with autonomy – who's version of a 'good outcome'?

An element of the values held by professionals established within previous sections was that rehabilitation was a process which facilitated improvements in function (often focussed on physical function and mobility) and that an evaluation of rehabilitation potential was based on a judgement about the likelihood that engagement in a rehabilitative process would bring about desired changes in mobility and function. However, due to lack of an explicit goal-setting process, particularly on the base ward, this represented an imbalance between beneficence and the autonomy of the individual, and perhaps was more of a well-intentioned paternalistic approach to determining a good outcome.

A multi-centre cohort study exploring patient goal-setting in post-acute geriatric rehabilitation found that goals relating to mobility were overwhelmingly the most frequently reported by patients (Kus, 2011). Therefore in this context, it could be suggested that practitioner reasoning was based on well-intentioned generalisations from evidence. It is perhaps an understandable (although not unavoidable) reality that, within the constraints of acute hospital care where an explicit goal-setting process would be time intensive, particularly with frail older adults often with additional challenges of cognitive or sensory impairments, practitioners were relying on pattern recognition and population-based understandings to formulate goals for rehabilitation. Practitioner extracts presented in interviews did recognise that this was not truly patient-centred although expressed sentiments that they still believed the focus on improving mobility was in the best interests of patients. Notably however, practitioners also highlighted that this was becoming a default reasoning process.

Linked to the above, professionals placed a value on promoting mobility gains through rehabilitation and equated this version of rehabilitation as a process requiring time and intensity. Although not always, this did often subsequently equate to time within bed-based rehabilitation and often related to perceived deficiencies or waiting times for community based rehabilitative services. This then leads to another critical question as to whether, if meaningful alternatives and consequences were explained, time spent in bed-based rehabilitation would be how an older person would want to spend their time when, a trajectory over time will, inevitably for some, be one of functional decline.

This is unquestionably a challenging question for patients, families and professionals alike although one where honest dialogue between all parties could assist. This honest dialogue was observed in the example of Patient 1, where a long discussion between the occupational therapist and patient’s daughter acknowledged limited recent progress and the risks associated with prolonging a hospital stay. However, this took place on day 44 of the admission, after time had been spent treating acute medical issues whilst simultaneously trying to facilitate functional improvements which ultimately were not consistently achieved. Honest dialogue at an earlier stage, and involving the patient themselves where appropriate, could begin to develop understanding on this challenging issue. That is to say, in simple terms, whether time spent in hospital – often (but not always) as a person nears the end of their life – is the way people would choose to spend their time if offered an honest appraisal of the risks and potential gains.

Parallels can be drawn with a model of 'Advance Care Planning'; a model to facilitate advanced discussions about wishes and priorities for care, established in palliative care and now growing within dementia care (NHS, 2007; NHS England, 2017). The advance care planning principle is that a voluntary discussion (with documentation of the outcomes) can happen between any person and a health professional about priorities and wishes for the end of a person's life. However, in reality the model tends to be used when it is known someone is approaching the end of life, or it is anticipated they will lose capacity to make decisions.

Recent surveys highlight only 5% of people over 65 have been offered an opportunity to discuss an advance care plan, although a third of respondents indicated they would be interested in public sessions or discussing this with their GP (NICE, 2016c). This suggests that there is public interest in developing an open dialogue on this issue although both survey results and the local examples would suggest that this is happening at a very late stage of life, if at all. It is perhaps reflective of larger philosophical debates about the medicalisation of ageing and death, and the orientation of a health service underpinned by a belief that most causes of death or decline can be resisted, postponed or remediated (Al-Qurainy, Collis & Feuer, 2009).

Returning to the complexity of balancing beneficence and autonomy, in this setting, beneficence was felt to be taking precedence over autonomy. Critical voices have raised that prioritising autonomy is a ‘good’ in itself (O’Keefe, 2001) however some argue that within a rehabilitation context, many require paternalistic interventions with an aim of working towards autonomy in the longer term (Proot et al, 2000). It is perhaps not as simple as prioritising one or the other, but instead reinforces the need for reflective and deliberate reasoning, rather than reasoning based on default positions because of time and system constraints. Reflecting on the many instances of dubious involvement, choice and informed consent, alongside some of the examples of functional decline during rehabilitative care, perhaps neither autonomy nor beneficence was genuinely realised.

8.5.4. Fairness, justice and rationing

The principle of justice relates to fair distribution of resources and the discussion of this not only received significant emphasis within research findings, but has also permeated earlier discussions of utilitarian and deontological ethics. Rationing, a strategy linked to justice, has been discussed as the withholding of beneficial interventions to patients, mainly for cost-effectiveness reasons (Strech et al, 2009) and finding ways of working in attempt to fairly distribute finite resources (Schubert et al, 2008). The need for healthcare rationing has been described as ‘inescapable’ (Fleck, 2011; p156) in the context of the already well-documented demographic and social changes and against a complex economic and political background. This inescapable nature of rationing in everyday health care was witnessed during fieldwork observations and permeated decisions about priorities within daily caseloads, management of lists for weekend therapy, listing patients for bed-based rehabilitation, and decisions about referrals to other services.

More critically, rationing has been seen as a way of maintaining the appearance of a public service whilst reducing it in practice (Lipsky, 1980). And although decision-makers at a macro level – such as politicians and strategists – may indicate that resources can be distributed more fairly through efficiency savings and ridding the system of those who abuse it (Fleck, 2011) – this fieldwork would suggest that practitioners are still left with the inescapable, and often hidden, task of rationing on a patient-by-patient basis.

Examples and extracts from fieldwork not only illuminate instances of rationing, but also interestingly provide insight in to the creation of rules or principles to assist with rationing. Examples of rules included whether people with cognitive impairment could benefit from rehabilitation (‘with an MMSE of 10 we can’t really put reablement in as she won’t learn anything’), or when people were not demonstrating sufficient progress in rehabilitation and therefore interventions should be scaled back (‘this is potentially her new baseline, she’s not going to get any better. Especially because it’s been two consecutive days in a row [that the patient has needed the hoist]’).

Interesting, the use of the Mini Mental State Examination (MMSE) as a rationing tool received high profile attention and criticism when it was used in strategic decision-making by NICE on the subject of funding for dementia drugs (Moreira, 2011). Critics challenged the sensitivity of the tool to disease progression and level of functioning and suggested it was open to subjective administration (Ballard, 2006). In recent recommendations about Intermediate Care including Reablement (NICE, 2017), it is specifically highlighted that people should not be excluded from services because they have particular conditions such as dementia. Yet despite criticism of using a tool such as the MMSE to make rationing decisions, and specific policy guidance not to exclude on the basis of cognitive impairment, at a micro-level, practitioners were observed to use this practice to create their own criteria for rationing. Pre-existing cognitive impairment has been recognised as being associated with poorer functional outcomes following a hospital admission and whilst likely to be deeply layered and multi-factorial, the link to limited access to rehabilitation services for this group has been questioned

(Longley et al, 2018). Findings here suggest there could be some truth behind this suggestion.

Principles to assist with rationing were also observed to be based on tacit knowledge and open to subjective interpretation. In the example on page 194, the physiotherapist was required to ration the weekend physiotherapy service, interpreting who would benefit from mobility practice with a physiotherapist or physiotherapy assistant (in comparison to those where nursing staff could manage their mobility) and using knowledge of a specific ward to reason that someone potentially may stay in bed all weekend without physiotherapy-led intervention. In this example there was also a suggestion that the negotiation with the wider physiotherapy team about the value they place on weekend physiotherapy for their own patients would influence the list and rationing of the service as a whole. For all of these reasons, it is easy to see how decisions reached by individual therapists could differ from another professional, influenced by their own tacit knowledge and a different set of contextual factors.

Strategies used to assist with rationing were presented in chapter six, including explicit and established strategies such as waiting lists and triage, alongside less overt strategies to assist with the gatekeeping of a finite rehabilitation resource. Links to the influential work of Lipsky (1980) were hypothesised in the literature review and it is in such examples where health professionals could be seen as ‘street-level bureaucrats’. Lipsky describes street-level bureaucrats as having the power to deliver benefits and sanctions and as constantly being torn by the demands of service recipients (in this case, patients and relatives) and by the demands of the organisation (and perhaps the population) to ensure the effectiveness and efficiency of the service. People who find themselves in this position determine how people experience state policies first hand and find themselves acting as mediators between the state and any given individual. Hammell (2007) offers further insight in to this issue for Allied Health Professionals (AHPs), suggesting that there are institutional processes that professionals actively reinforce which may disempower clients and go against fundamental principles of person-centred practice.

8.5.4.1. Rationing based on appropriate or deserving behaviours

Controversially, Lipsky suggests that citizens who receive public benefits interact with public agents who require certain behaviours of them. In this case, patients interact with health professionals in order to receive interventions to benefit their health and wellbeing, but judgements about appropriate behaviour and conduct may influence the health professional in this important gatekeeping role.

Although small in number and influenced by a wide range of factors, the use of positive descriptions by health professionals observed during fieldwork – such as ‘she’s lovely’, ‘she’s delightful’, ‘she’s my favourite’ - was obvious within handover meetings, weekly multi-disciplinary meetings and within other informal times of discussion and information exchange. In contrast, the creation of accounts around difficult or challenging patients - ‘refused assessment’, ‘not trying’, ‘wife destructive to care’ - was also witnessed with no instances of such accounts being challenged or counter-narratives created At a surface level, such accounts simply emphasise the emotional element of professional practice and that professional decision-making can be influenced by emotion and values.

At a deeper level, insight in to such accounts can be linked to creating narratives around good or bad patients; those who are deserving or undeserving of services. The labelling of good and bad patients is an idea which is supported by research (Sointu, 2017; Dingwall & Murray, 1983) and again is of interest to the social constructionist researcher. Due to the realities of finite resources, it is reasonable to suggest that the narratives about deserving and underserving patients may then form a foundation which informs the allocation of time, care and services. On some occasions, the narrative of good or bad patients was associated with favourable or less favourable outcomes (presented on page 196).

Through a closer look at the examples in this study, the good patient was understood to be one who was complying with the social norms of the institution, such as adhering to health professional advice and engaging positively in health professional interactions. The bad patient, in comparison, was often one who was interpreted to have refused advice or interventions, and therefore was potentially disrespecting the unspoken hierarchy of the system. These themes are echoed in a study by Sointu (2017) exploring good and bad patients from the perspective of medical students. Sointu suggests that good patients are characterised by features such as being motivated, knowledgeable, compliant and active in their care and these patients were then seen to be afforded more time, care and appreciation.

Finally professionals regularly cited patient motivation as a key influencing factor in their evaluation of rehabilitation potential and it has been hypothesised that motivation may form part of the narrative around a good or deserving patient. It is an area which warrants further exploration, although a narrative created and upheld about a demotivated patient could feasibly equate to rehabilitation potential being quickly ruled out.

8.5.4.2. Manipulating the nature and quality of information to assist with rationing

Lipsky suggests that client demands will be expressed only to the extent to which people are aware that they have a need or condition that could be met by a public agent. He goes on to suggest that withholding information about a service inevitably depresses service demand. Firstly, in relation to this project, neither the term rehabilitation potential, nor the reasoning process to evaluate potential were observed being explicitly explained to patients, which could be said to be putting patients at an immediate disadvantage with limited information.

Lipsky also suggests that patients will only make demands for interventions or services to the extent to which they know they are available or that they could be accessed by them. As outlined in the findings, it was common that information about a service or intervention would not be communicated to patients unless it had already been decided that the person would benefit from this service. In this way, patients deemed not suitable for a rehabilitation resource (such as weekend therapy) would often not be aware of the existence of these services or that they had ever been considered.

In the case of referring for community rehabilitation (such as community physiotherapy), professionals discussed openly that there were occasions when they decided not to refer patients because the waiting list was too long. This decision-making process or outcome was then not observed to be communicated to patients, although and not documented in records. One consequence of this was that patients were never fully aware that they had a need that could be met by this service and therefore did not make any demands for it. However, Lipsky also proposes wider consequences of practices such as this in that, at a macro and strategic level, organisations often ration services at a community and population level based on information from referrals, waiting lists, and contacts. Through practices such as failing to refer, and failing to let people know that services stand ready to assist if patients think they have unmet needs, Lipsky suggests that professionals, and in this case health professionals, are contributing to data which suggests low demand. It is interesting to reflect on this in light of a reduction of bed-based intermediate care provision and perceptions that community rehabilitation was under-resourced.

Where there is a lack of alternatives or patient preferences cannot be acted on because of resource limitations, engagement and involvement should focus on education about realistic and available options (Kimmel et al, 2017). This was observed in part – for example where referral to the reablement service had been determined to be inappropriate, discussions took place about long term care packages including how to refer and potential costs. However, once again, this was observed to happen in an ad-hoc way and the presentation of alternatives or reasons for a service being unavailable or unsuitable were not always clear.

8.5.4.3. Is justice and fairness realistic for older people?

Despite being the biggest users of acute hospitals, the acute hospital system is increasingly orientated away from the needs of people with complex presentations and co-existing conditions. The high profile that specialisms attract in terms of funding and research, the ongoing separation between physical and mental health services, and the lack of integration of health and social care could also be seen as disadvantaging the largest group of hospital users. The introduction of comprehensive geriatric assessments and development of specialist models of service provision, such as frailty assessment units, or in-reach frailty teams are going some way to recognise and address the issue (Edmans et al, 2013). Evidence suggests such developments may go some way to improve outcomes for this population – such as improving the likelihood that people will be alive and in their own homes at follow-up (Ellis et al, 2017). However, patient and carer perceptions suggest their experience is less positive (Darby et al, 2017) and many of the issues above represent overriding and systemic barriers facing an older person in relation to receiving fair and just services within an acute hospital system.

The issue of resources within the acute hospital system was inescapable during time spent within this field. The closure and re-provision of intermediate care beds and the perceived deficiencies in community rehabilitation services for older people were frequently discussed by professionals. Professionals shared feelings of pressure that this created and also, through comparisons with the funding allocated to more specialist branches of rehabilitation (such as the stroke rehabilitation ward and the community stroke team), shared the perception that the organisation did not place value on general rehabilitation targeted at the frail, older population.

Wade, in his four-part critical commentary suggests limited funding, low profile and inadequate provision are realities of rehabilitation practice (2015). Returning to neo-liberalist politics, it could be argued that the issue of cost effectiveness is the most critical one, and the evidence for cost-effectiveness of rehabilitation is not only limited, but measurements are controversial and the subject of debate. Measurements frequently utilise data in relation to contribution back to society (in terms of return to employment) and reduction in dependency on care services. Not only is the relevance to an older population questionable, but the extent to which this benefit accrues to health services (rather than social care) is not immediately obvious. Coupled with crude estimates that the cost benefits of rehabilitation may take between 1-5 years to pay off (Turner-Stokes, Paul & Williams, 2006), the critical challenge to commissioners is whether spending on rehabilitation for frail older people is a worthwhile endeavour. Although not explicitly acknowledged in this way, this may be suggestive of the ‘fair innings’ debate discussed in relation to equitable health services, intimating that scarce resources should be allocated to those judged to have the longest life left to live and largest contribution to make back to society (Hicks, 2011; Lane et al, 2017). Reflecting on this, even before entering the system, and before becoming the subject of individual decisions, older people face challenges to fair and just services.

It is important to note that rationing on the basis of age, or a ‘fair-innings’ attitude was not observed at the level of individual professionals or within clinical teams. Indeed, the desire to give people ‘a chance’ communicated an intention that health professionals wanted to facilitate positive outcomes for all patients, irrespective of age. However, this is not to say that issues pertaining to age did not influence professional reasoning in other more implicit ways. There were examples where professionals clearly recognised that, in their attempts to manage the competing demands of their own workloads, they potentially disadvantaged older people. The most obvious examples related to involving older people directly in care and decision-making with professionals recognising that when time was limited, meaningful involvement of older people became more challenging, with short-cuts such as gaining information from relatives, becoming a recognised and default practice.

There were also other critical examples which would benefit from reflection. Professionals within the study suggested that the organisation placed value on fast-paced patient trajectories and encouraged them to prioritise those patients where transfer of care could be achieved most quickly. Occupational therapists clearly stated that they were unable to prioritise patients who already resided in 24-hour care environments. The study also revealed examples of health professionals creating their own justification for the rationing or withholding of services – for example stating cognitive function scores which indicated that progress through rehabilitation was unrealistic; patients who had already received services had already had a 'chance' at rehabilitation; and the time that it would take an older person to participate in a rehabilitation session created more pressure when compared to a patient of a younger age.

Alongside this, professionals discussed conceptualising rehabilitation potential as not just potential to benefit, but potential to get back to a baseline level of function, and yet the contrary outcome of older people being vulnerable to decline during a hospital admission has been discussed in earlier sections (Covinsky et al, 2003). The significance of motivation for, and active engagement within, the rehabilitation process has also been discussed although yet again, literature would suggest that prevalence of low motivation and mood disorders in hospitalised older people is a significant issue (Royal College of Psychiatrists, 2005).

Considering all of these factors, a significant and challenging landscape emerges of the numerous challenges faced by older people potentially contributing to universal disadvantages when it comes to the allocation of finite rehabilitation resources.

8.5.5. Ethical distress for professionals

The verbatim extracts presented in section 6.2.5 illuminate notable differences between how professionals would like to practice, and the realities of their service provision. The difference between ideal and real-world practice provoked a number of responses, from general feelings of challenge and discomfort, to feelings of guilt, and to actions orientated towards blaming others.

These feelings of tension and challenge were perhaps being experienced in a deeper way by different professionals at different points in time, and could be equated with the concept of ‘ethical distress’ (Durocher et al, 2016; Bushby, 2015; Mendes, 2017), originating from the seminal work by Jameton (1984). According to Jameton, ethical distress is experienced when a person knows the right thing to do but institutional constraints make it difficult to pursue this course of action. There are differences between situations of ethical uncertainty (where someone may not be sure of the right course of action) and situations of ethical dilemma (where a person faces two or more situations with perceived equally positive or equally negative outcomes). A more recent definition suggests that ethical distress is “the experience of being seriously compromised as a moral agent in practicing in accordance with accepted values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural context of the work-place environment” (Varcoe et al, 2012; p59).

One participant directly talked about the issue of compromise in their practice (page 192) and Mendes (2017) suggests that distress emerges because of a compromise in values when the right course of action cannot be taken because of perceived constraints.

Insights shared by participants, such as their desire to talk to patients but talking to families instead (page 184), the desire to focus on wider functional goals rather than just mobility (page 139) and the desire for intensive therapeutic interventions but being limited by time (page 169) all strongly resonate with the professional compromises suggested above and therefore may have been contributors to ethical distress. Examining the examples alongside language used in the descriptions, such as 'uneasy', 'frustration' and 'failing patients' adds further insight in to the personal and professional distress experienced. Alongside this, throughout many aspects of observations and interviews, practitioners retold stories of challenging practice situations, which Carpenter (2010) suggests is indicative of people carrying the remnants of professional compromises or situations they have been unable to satisfactorily resolve.

More globally, the desire to bring about positive outcomes (discussed extensively in section 8.5.3) but feeling compromised and constrained in their attempts to deliver a 'proper' version of rehabilitation could also be linked to ethical distress. The extent to which practitioners were aware of the limited functional improvements suggested in the narratives captured during patient tracking was not fully clear, although the distress and frustrations communicated suggest insight at either a conscious or subconscious level.

Authors who recognise that ethical distress exists for healthcare professionals, also reflect that professionals will use various strategies to manage and minimise the effects. Professionals will use resourceful and creative ways to advocate for patients and potentially 'get round the system' in attempts to find concessions and ways forward which are acceptable for the patient, to the organisation, and to professionals' own morals and values (Wong, 1992; Carpenter 2010). It is here that Lipsky's detailing of the role of *Street Level Bureaucrats* (1980) once more emerges as influential to this discussion. The presentation above of strategies used by street level bureaucrats was mainly linked to the desire to ration a public resource and attempts to translate overriding strategies and policies in to actions for individuals who require state involvement. However, these strategies were also potentially fulfilling an additional purpose – that is to say, helping to minimise the feelings of powerlessness and distress experienced if service delivery was compromised through systemic pressures.

Although street level bureaucrats are criticised for creating their own rules and subjectively interpreting them in different contexts, the creativity and resourcefulness required to do this suggests a sense of control and empowerment in otherwise disempowering situations. This resourcefulness and creativity could be seen in the imposition of changing the perspective on the concept of baseline (and how professionals circumnavigated the guidance in order to still utilise the word and concept), or how professionals advocated for particular patients in order to facilitate desired outcomes. However, although such strategies may have energising potential and promote feelings of professional accomplishment, there are also inherent dangers and risks potentially resulting in inconsistencies or inequities and a lack of respect for wider roles (Carpenter, 2010).

An additional strategy suggested is the use of standards, guidelines and in particular, professional codes of conduct, to provide guidance in situations of ethical uncertainty (Mendes, 2017). However, on closer examination of codes of conduct, statements about fairness and equality are based on broad recommendations linked to common determinants of inequalities such as race, age and gender (RCOT, 2015; CSP, 2011) with little in the way of strategies or practical support to manage more intricate equality issues. Indeed, Edwards et al (2011) suggest that although codes of conduct attempt to include broad statements to acknowledge societal obligations and a commitment to collective health and wellbeing, underpinning such codes with the four individualist principles and with a particularly under-developed, un-critical understanding of the concept of justice, mean they offer insufficient support for practitioners to enact true ethical practice. Hammell (2007) also questions whether professional codes of conduct, which suggest commitment to needs led, person-centred services, offer realistic guidance for contemporary practice where professionals are tied by their role of resource gatekeeper, with an allegiance to the institutional system. The participant quote that it is the ‘resources that win’ highlighted the reality of this institutional allegiance.

To conclude this section, and before progressing to the consideration of professional roles in decision-making, it is important to return to the many influences on the evaluation of rehabilitation potential, a central area of enquiry for this study. These influences, including the influence of ethical dimensions, and the use of strategies to manage some of the pressures, are visually represented in Figure 13. The three inner layers, represent layers of factors considered by professionals as they evaluate whether a person has capacity to benefit from rehabilitative interventions. However, the boxes which surround these layers represent other influences on professional reasoning, with many areas of ‘push’ and ‘pull’, and tensions between different influences. The box below the lower line represents areas which were rarely vocalised or observed but were implicit influences on reasoning and decision-making.

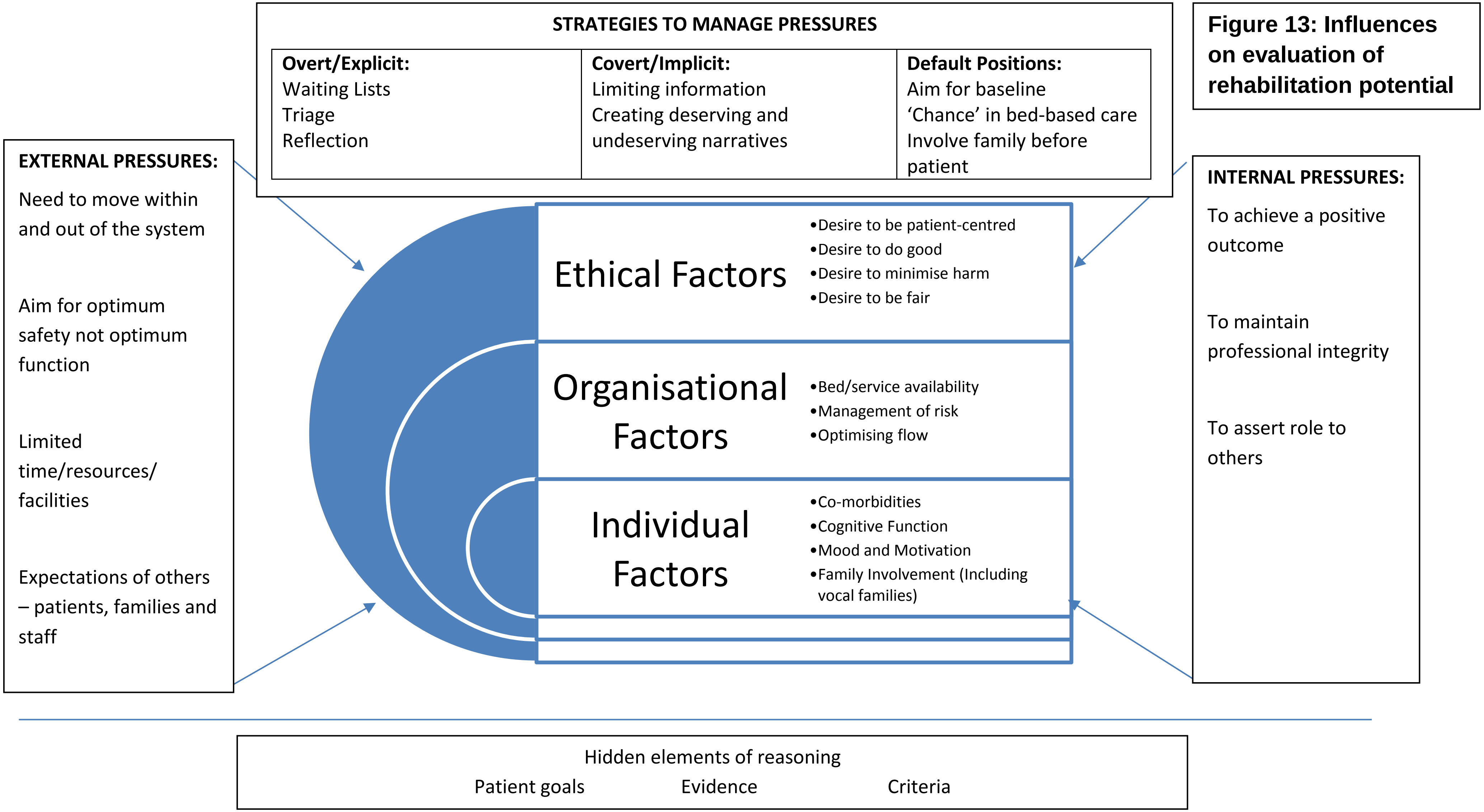


Figure 13: Influences on evaluation of rehabilitation potential

8.6. The centrality of the physiotherapy role in evaluating rehabilitation potential and making decisions about pathways

The importance of the physiotherapist in evaluating rehabilitation potential clearly emerged from findings and was noted by physiotherapists themselves, by occupational therapy counterparts and by other members of the team. This was linked to the joint focus of physiotherapists on treating acute medical issues and improving mobility, both areas being part of a dominant discourse in this setting. Not only was this value communicated by individual professionals, but institutional developments also emphasised value placed on physiotherapists as the main agents in the delivery of active rehabilitation interventions (for example the ‘Green Day/Red Day’ initiative described on page 142)

The importance of the physiotherapy role was also linked to the frequency and intensity of involvement in direct patient care in comparison to occupational therapists (Table 6). Information from patient tracking suggested that more patients within the base ward and rehabilitation ward had traditional physiotherapy needs, reflecting earlier and higher intensity physiotherapy input and a more prominent physiotherapy role. Findings such as this are reflected in other studies of patients on acute and rehabilitation wards, where more patients are determined to have physiotherapy needs than occupational therapy needs (Hubbard et al, 2004).

Studies also suggest that older patients tend to have better awareness of the physiotherapy role than the occupational therapy role during an acute hospital admission (Atwal et al, 2007) which could also be linked to more frequent involvement and clearer purpose. In this study, there was evidence of patients more readily associating with the physiotherapy role – for example Patient 5 believed that his physiotherapist had been present on a home visit, even though it was actually the occupational therapist who was present. Whilst not necessarily being significant in and of itself, it is reflective of the broader importance associated with the physiotherapy role.

8.6.1. Locating occupational therapy and physiotherapy within the acute care hierarchy – issues of power and decision-making authority

Issues of hierarchy and power within health systems could become the focus for a full thesis. However, the hierarchical position of the occupational therapist and physiotherapist role is worthy of reflective discussion here, primarily because of the direct relevance to their authority within rehabilitation decision-making and because a comparative exploration of the difference in occupational therapy and physiotherapy roles was an objective of the study.

Despite many researchers and policy makers bringing attention to issues of power and hierarchy, traditional medical hierarchies persist within healthcare services and systems, perhaps nowhere more obvious than the acute general hospital (Willis, 2006; Nugus et al, 2010). The traditional hierarchy of the doctor being the decision-maker was evident in this setting with occasions noted where the judgement of the doctor was observed to override other professionals; or required to form alliances in order for the opinions of other professionals to hold value (pages 160; 202).

Findings provide support for the notion that physiotherapists had a greater standing within the social setting than occupational therapists. Furthermore, and in relation to the traditional medical hierarchy, it could also be hypothesised that the position of physiotherapists was partly influenced by their proximity to doctors, whose own position and standing was greater still.

Whilst there are studies which acknowledge or allude to the existence of healthcare hierarchies, literature which more specifically explores hierarchies within rehabilitation settings or issues of power and hierarchy for occupational therapists and physiotherapists are notable by their absence. Yet such observations of position and power within the social space are of clear interest to the social-constructionist researcher. Equally, how professionals mobilise power in their actions – in the case of this research, how they influence and make decisions – is of particular interest here.

With a paucity of contemporary, discipline-specific literature, the seminal work of Pierre Bourdieu (1984; 1989, 1993) provides explanatory theoretical frameworks to support further exploration. Bourdieu discusses his concept of 'field' as a structured space of positions which imposes determinations on all those who enter it and hierarchies within the field are arranged in respect of certain types of power or capital (Bourdieu, 1993). Individuals and groups accumulate 'capital' over time, based on dominant values and discourses, and capital can also accumulate based on the proximity people and groups have in relation to others. Types of capital include economic capital (capital accrued through financial assets and resources), cultural capital (capital accrued through language, possessing cultural objects and acquisition of styles and tastes), social capital (resources mobilised through membership in social networks) and symbolic capital (resources created from social position and prestige). Capital can manifest itself in skills and behaviours which match the standards of dominant institutions and therefore can be utilised to produce meaningful situational advantages.

Applied to the social space of the healthcare team within this context, it is perhaps acceptable to hypothesise that the medical team were, through historical and established professional esteem, and through the dominance of a biomedical model of health and illness, positioned highly in terms of cultural, social and symbolic capital. In this setting, and over time, it could be proposed that physiotherapists had developed proximity to the medical profession by closely affiliating through language and skills and therefore accrued their own multi-dimensional capital in this setting. Physiotherapists and doctors were able to talk with more frequency and regularity about shared patient cases – linked to physiotherapists knowing the majority of patients at an earlier part of the patient pathway. Physiotherapists also possessed knowledge (and a shared language) of acute medical problems and interventions and collaborated with the medical team to manage some of these concerns.

Perhaps less obvious although worthy of note, physiotherapists shared the same physical environment more frequently with the medical team (that is to say, they were observed to be present on the base ward with more frequency) in comparison to the occupational therapist (who was observed to be more frequently based within a departmental base). All of these elements raised the social, cultural and symbolic capital held by physiotherapists, who could then translate this capital in to value placed on actions and decisions. Bourdieu's principles would suggest that situational advantages can be gained through this and the extracts presented on page 202 suggest that the physiotherapist opinion was held in high esteem. The application of Bourdieu's construct suggests that such positions of authority and power do not emerge by chance or in response to individual personalities or dynamics.

Extending the application of these concepts, it could be further hypothesised that this framework provides insight in to the position of occupational therapists within this social space. Whilst a proximity between medicine and physiotherapy was noted, a distance between medicine and occupational therapy was also observed. This was recognised by one occupational therapist who suggested that their stronger alignment with a social model of health and disability created distance from dominant norms and affected the influence of their profession (page 207). There is also support for this within literature with occupational therapists reporting feeling intimidated by doctors (Lohman, Mu & Scheirton, 2003) and struggling to assert their role in interactions with medical professionals (Robertson, 2012).

In this study, it was acknowledged by occupational therapists themselves, alongside implicitly being acknowledged within the wider team, that occupational therapists were perceived as less influential in the rehabilitation environment and within rehabilitation decision-making. Bourdieu’s theories would equate this to occupational therapists possessing lower quantities of capital, particularly symbolic capital. The alliances that occupational therapists formed with others – particularly with physiotherapy (examples discussed on page 209) - represented a way of creating proximity to a group who held more in the way of resources and capital.

Another critical way in which occupational therapists were creating proximity to physiotherapy and medicine, and therefore to a biomedical model of health, was through the alignment with a version of rehabilitation orientated towards improving physical health and particularly mobility. Manifestation of this included words used in their discussions of rehabilitation (pages 138; 154), and that occupational therapists were often observed giving feedback in team meetings in relation to physical elements of functioning, such as transfers and mobility. This is echoed in wider research where occupational therapists are found to express their work in biomedical language because a focus on wider aspects of occupation is not understood or potentially valued (Murray et al, 2015).

Although physiotherapists were perceived as potentially holding more power than occupational therapists, significantly it was not a power that was observed on the surface to be divisive or competitive. However on deeper reflection, although occupational therapists did not appear to be dominated by, or in conflict directly with, physiotherapy or wider colleagues, extracts are suggestive of internal and external struggles (page 206) related to attempts to legitimise knowledge and values which are essentially in contrast with dominant discourses.

It is important to emphasise that alongside such struggles, there was evidence of collaborative relationships. The interview extract on page 210 suggest physiotherapists and occupational therapists emphasise their similarities rather than their differences. There were also features resonant of a concept named as collaborative power (Nugus et al, 2010); a concept to describe the way power is utilised to maximise the potential of both distinctive and overlapping roles. Such features between physiotherapists and occupational therapists included facilitative information-sharing (such as sharing information to help identify when a patient was ready for occupational therapy assessment), and appropriate role distinctiveness and interchangeability (for example, physiotherapists distinguishing their role in mobility assessments, but both professionals contributing to assessments of transfers, mobility in the home environment and moving and handling plans).

These examples provide a platform for professionals to recognise how to harness collaborative power, although this may be reliant on a tacit understanding of roles and influenced by personalities within this context. The emphasis on collaboration rather than conflict should therefore not be taken for granted and could emerge within different teams or at different times.

It is important to note that this analysis of the hierarchies and positions within this particular field, but as situated within the larger thesis with broader research objectives, has, through necessity, presented a brief and concise overview. It does not discuss the position of the many other individuals, groups, organisations or institutions which act within, and influence, the structure of this space. A deeper analysis could, for instance, also illuminate positions adopted (and struggles faced) by physiotherapy, medicine and others in relation to wider dominant values held by organisations and institutions. And perhaps significantly, it could also provide a framework and vocabulary to discuss the critical position of patients and families.

Attention must also be paid to limitations with Bourdieu’s version of the organisation of the social world. A frequently cited criticism is the deterministic nature of his theories, with some suggesting that his conceptualisations provide little acknowledgement of how individuals and groups can influence social action or transformation (Fowler, 2000). His concepts are also highly political and therefore attract disciples and extreme critics (Swartz and Zolberg, 2004). However, Bourdieu’s concepts have enabled observations about how contrasting sets of knowledge and experience (specifically for occupational therapists and physiotherapists) potentially translated to position and capital within the social space and have presented important opportunities for reflection.

8.6.2. Challenges to both disciplines from systemic constraints

A clear understanding emerged from fieldwork and interviews that both occupational therapists and physiotherapists felt pressure created from systemic constraints. Issues such as a lack of time, the focus on fast-paced turnover and trajectories, and perceptions about wider resources such as access to follow-up services were highlighted by both professions. Many of these issues contributed to examples where both disciplines felt they were unable to provide best (or ‘proper’) practice for their patients.

Whilst frustrations were evident across both groups, it was perhaps notable that occupational therapists also presented as experiencing challenges with professional identity, compromises to professional practice and issues relating to professional confidence, issues which were not notably obvious from physiotherapists. All of these themes were almost identically echoed in a scoping review of occupational therapy practice in acute hospital settings in Australia (Britton, Rosenwax and McNamara, 2015) and reflect real challenges for the profession in this area of practice. In contrast, for physiotherapists, the extract presented on page 209 suggested that despite frustrations they were managing to practice with a sense of confidence and value.

It is important to note that this may have been influenced by the experience level of the professionals involved in this study and whilst detailed information about time since qualification and grades of staff was not a focus (and deliberately not presented to ensure anonymity in such a localised context), general observations include the fact that the physiotherapy team included a higher grade therapist (Band 7) than the occupational therapy team (Band 6) and that some of the occupational therapists involved were relatively new to their roles. It is also important to note that, as an occupational therapist, I also may have been more focussed on examples pertaining to her own profession

However, as challenges to confidence and professional identify have been recognised as consequences of ethical distress, one explanation could be that occupational therapists were experiencing this distress to a greater extent than physiotherapy counterparts. Literature suggests that occupational therapists in acute care are particularly vulnerable to feelings of distress through occupational alienation. This refers to situations where the purpose of their labour becomes increasingly orientated away from a client-centred approach to practice which focusses on the central tenet of meaningful occupation (Durocher et al, 2016). Furthermore, professional dissatisfaction is reported among occupational therapists who feel they are unable to focus on their key domain of concern (Wilding & Whiteford, 2009). Practice observed in this study, alongside the narrative shared during interviews, suggested that rehabilitation did not focus on wider occupational, social and emotional aspects of health and recovery and this was being keenly felt by the occupational therapists involved.

The orientation of rehabilitation and rehabilitation decision-making towards safety, rather than a wider philosophy to address holistic needs, is increasingly recognised

(Durocher et al, 2016; Durocher & Gibson, 2010). Although this is of concern to all rehabilitation professionals, because safety was also intrinsically linked to mobility, it is likely that this was minimising the impact of this tension for physiotherapists, whilst being felt more acutely by occupational therapy counterparts. At the same time, it could be argued that resilience amongst this group was already at a low due to issues of power and perceived value.

8.7. Chapter summary

Hammersley and Atkinson (2007) discuss that it is not enough for ethnographic writing to be persuasive or rich in descriptive detail, but that it also needs to demonstrate the adequacy of the scholarly claims. It is in this chapter, through links to policy, research and theoretical frameworks, that the presentation of findings, and the many questions raised, are placed within a macro socio-political context, illuminated by wider professional knowledge.

The wider contextual and cultural background presented within this discussion serves to provide explanatory frameworks for values and positions which are evident within rehabilitation practices in this setting and which underpin how the concept of rehabilitation was understood.

Due to the centrality of the concept to the research aim, the meaning and interpretation of rehabilitation potential has been developed further in this chapter, considering the ambiguity and blurring of the concept and raising challenges and questions for professionals and patients. Many of these questions have begun to frame implications for practice outlined in the concluding section.

The language and examples reported in the findings section pertaining to the ethical dimensions of decision-making led to links with a concept of ethical distress which is reported in wider literature. In part due to the power of this distress communicated through fieldwork experiences, ethical dimensions have received particular emphasis within this interpretation. Critical questions and challenges have again been posed, such as whether justice can be achieved for older people, and the extent to which good outcomes and improvements can be realised. The chapter concludes with a section which compares and reflects on occupational therapy and physiotherapy roles within rehabilitation decision-making and recognises the value and esteem placed on physiotherapy in this context. Once again this paves the way for important implications for practice discussed in the next chapter.

CHAPTER NINE – CONCLUSION

9.1. Chapter introduction

This research set out to explore health professional's decision-making in relation to the assessment of rehabilitation potential of older people in hospital and recommendation of subsequent rehabilitation pathways. It was motivated by my own previous experience of being involved in such decisions and by a lack of evidence which focussed on understanding real-time decision-making in the context in which it occurs. The focus on acute hospital admissions and rehabilitation pathways for a heterogeneous population of older people was developed when a review of the literature highlighted that such issues were largely underexplored for this group, despite being the largest users of acute hospital services.

Because of these themes, a qualitative study was designed, from a social constructivist stand-point, utilising principles of ethnography and case study research. In order to set some parameters for the purposes of data-collection, one ward was identified as the main-unit of analysis and physiotherapists and occupational therapists were the main rehabilitation professionals focussed on within the study.

9.1. Summary of key findings

It is important, at this concluding stage, to revisit the objectives of the study and discuss how the knowledge and understanding generated can be understood in relation to these objectives.

Objective 1 - To explore the meaning of the concepts of ‘rehabilitation’ and ‘rehabilitation potential’ to occupational therapists, physiotherapists and patients

Professionals in this setting recognised that the concept of rehabilitation was influenced by wider social and cultural factors such as the public interest in, and relatively higher profile of, rehabilitation of war veterans and rehabilitation of athletes. This could be suggested to lay a foundation for rehabilitation as a process which improves the strength and function of the body. Within the context of this ward and acute hospital, there were further factors which added layers to this conceptualisation. Set against a backdrop of neo-liberal politics, the NHS Trust was driven by targets – for example optimising flow out of the system. Optimising physical function, and more specifically mobility, was seen as being directly linked to such targets.

Physiotherapy was noted as the dominant professional in delivering rehabilitation, linked to their central domain of concern focussing on improving physical abilities and mobility. However, the causality question of ‘chicken and egg’ requires consideration here – did a dominant physiotherapy role contribute to mobility being the main focus of rehabilitation, or had the emphasis on mobility centralised the physiotherapy role. My own reflection was that elements of both were evident although the central focus on mobility would likely exist and endure because of many other influential factors.

There are many tensions between this conceptualisation of rehabilitation and the philosophy of rehabilitation professionals, who verbally reported a commitment to a multi-disciplinary, holistic, and patient-centred paradigm but recognised that the version they experienced fell someway short of this ideal. More specifically, this reductionist version of rehabilitation as a process to improve mobility posed particular challenges for occupational therapists, although they were observed to align their practice with this dominant discourse.

Alongside this focus on rehabilitation as a process to facilitate improvements in mobility, and physiotherapists as the primary providers of rehabilitation, rehabilitation was often seen as a place, rather than a phase of care. This was problematic in that patients then waited for rehabilitation, were re-prioritised whilst waiting, and sometimes needed a potentially disruptive move within the system if medical needs became a priority.

Unsurprisingly, the meaning of rehabilitation potential was found to be ambiguous, subjective and open to interpretation in relation to contextual factors. However, the localised examples shine a light on how decisions about rehabilitation potential were being enacted and frequently this was associated with a judgement about the potential of a patient to make gains and improvements in mobility. Importantly, this evaluation was found to be intrinsically linked to high-stakes decisions for patients (such as whether they would move to a rehabilitation bed) and those who made decisions about rehabilitation potential therefore could be seen as adopting a high-stakes, sometimes controversial, gatekeeping role.

In part due to limitations in the methodology, the concepts of rehabilitation and rehabilitation potential from the patient perspective were relatively under-explored. However, through my own exposure to the constructs in real-life and real-time, the terms were not regularly explained to, or used with, patients and families. One of the main manifestations of this was a difference in expectations between professionals and patients of what rehabilitation would entail and what potential could realistically be achieved.

Objective 2 - To map the reasoning process of health professionals involved in evaluating rehabilitation potential and when making decisions about rehabilitation pathways for older people

Professionals did not have any objective criteria to assist in their evaluation of rehabilitation potential and the use of assessment tools (such as a frailty assessment) which may have assisted to recognise those older people who could benefit from, or decline during, a rehabilitative phase of care were also not observed to be in use. Instead of criteria, practitioners were observed to use their own rules to assist them to reach and rationalise decisions. In such instances, subjectivity and individual interpretation were particularly noted.

Decision-making involved a tacit reasoning process which was broadly understood in terms of the following stages: gathering baseline information and carrying out initial assessments; awaiting (or providing) supportive and curative interventions to treat medical issues; providing initial rehabilitative interventions and allowing time to monitor response and carryover; and making an evaluation of likely rehabilitation potential to inform the subsequent pathway.

Engagement with a rehabilitative process to inform a decision about rehabilitation potential was an important part of reasoning, in that professionals valued seeing the response to, and carryover from, early rehabilitative efforts in order to evaluate ongoing potential. The critical challenge here was that there was a perceived absence of ‘proper’ rehabilitative interventions and a facilitative rehabilitation environment, which could suggest that subsequent evaluations were fundamentally problematic.

The process of evaluating rehabilitation potential involved health professionals managing ethical dimensions and, sometimes competing, ethical demands. Health professionals communicated their commitment to the ethical principle of beneficence and their desire to bring about a good outcome when making decisions about rehabilitation potential and rehabilitation pathways. However, in the absence of an explicit goal-setting process, this could be seen as paternalistic and based on questionable evidence. Whilst maintaining this desire to bring about positive outcomes, professionals were attempting to balance other ethical dimensions including managing the demand for diminishing rehabilitation resources, and working towards fairness and autonomy for older people.

Because of this, the reasoning process therefore developed reasoning and strategies to manage ethical demands and challenges. Some of these strategies were overt, such as the use of waiting lists and triage, although some were more covert, such as creating narratives about deserving patients or manipulating information giving in order to manage demand. The personal ethical distress suggested in the language of health professional interviews suggested that these tensions were not easy to reconcile.

Objective 3 - To compare the occupational therapy and physiotherapy role in evaluations of rehabilitation potential and decisions about rehabilitation pathways

Despite recognising a reductionist focus on mobility, both occupational therapy and physiotherapy professionals presented as aligning their practice with this version of rehabilitation. Physiotherapy tended to take a lead role in the early stages of evaluating rehabilitation potential and attributed this to their model of working of seeing all patients on the base ward and often being involved at an acute stage. Occupational therapists were observed to get involved at later stages, and sometimes this involvement was limited or absent.

The multi-disciplinary team all placed value on physiotherapy evaluations of rehabilitation potential and recommendations of rehabilitation pathways. Multiple factors presented as contributing to this – physical improvement was the main (if sometimes implicit) goal of a rehabilitative process and physiotherapists tended to be the main protagonists in delivering these rehabilitative interventions. And because evaluations of rehabilitation potential tended to rely on information from monitoring such interventions, the importance of physiotherapy in evaluating rehabilitation potential and making recommendations about rehabilitation pathways also emerged. Occupational therapists could not always rely on knowledge from engagement with a rehabilitative process – an important part of evaluating rehabilitation potential – because they were not always involved early enough, and sometimes not at all.

Although both groups were subject to the ethical tensions from systemic pressures, this presented as being particularly felt by occupational therapists who also presented as struggling with issues related to the value of, and respect for their role, and their professional identity.

Objective 4 - To describe influences on decisions regarding rehabilitation potential and subsequent pathways

The evaluation of rehabilitation potential was influenced by a number of different factors in this context. Some factors related to the individual patient, such as baseline function, presence of co-morbidities, cognition and motivation, to name a few. Professionals placed particular emphasis on baseline function although critically information about this was sometimes observed to be incomplete or unclear. The reason baseline function was deemed to be important was that it gave an implicit goal about what the patient would have potential to achieve although during the course of fieldwork, professionals were being subjected to pressure to reframe this goal to focus on achieving safety rather than returning to a baseline norm.

Cognition and motivation were also discussed as being particularly influential. It was not observed that some factors were consistently more influential than others, but instead it was recognised that all factors could become important and influential either in different circumstances or for different individual patients. Again, the potential for subjective interpretation was evident.

The patient perspective of their rehabilitation potential and their preferences about pathways were discussed as being desired and deemed to be important, although in reality perhaps not as influential as other factors. Significantly, the concept of rehabilitation potential was not observed as being explicitly discussed with patients and therefore patient influence on, and involvement in, this evaluation would always be limited by this. Furthermore, patients and families were observed as being involved to varying extents in pathway decisions with those who could proactively vocalise this involvement observed as influencing such decisions in the most obvious ways.

Alongside factors individual to patients, wider factors were also influencing evaluations about rehabilitation potential. Perhaps because the concept of rehabilitation was strongly linked to place, and the concept of rehabilitation potential often was synonymous with the potential to benefit from going to a place or accessing a service, the overlap between decisions about potential and decisions about pathways became blurred. A resultant outcome of this was that decisions about rehabilitation potential became heavily influenced by availability of beds and services.

Objective 5 - To explore how patients and families are involved in evaluations of rehabilitation potential and subsequent recommendations regarding treatment and care.

Principles of shared decision-making and meaningful involvement were discussed as being desired but recognised as being challenging within this context. Barriers noted included the time needed for meaningful involvement and the extent to which patients and families wanted to share decision-making responsibility. Indeed, professionals recognised that time spent communicating with patients and families, and on activities such as involving family members in therapy sessions were prioritised out due to time pressures. This was recognised as being particularly pertinent for older people where such activities often involve greater time.

Earlier parts of this concluding section have acknowledged that decisions tended to be professionally-led rather than patient-centred and often linked to professionals giving patients a ‘chance’ to make gains through bed-based rehabilitation. Whilst acknowledging such decisions were well-intentioned, the small number of patients tracked during their admission showing lack of improvement (and in some cases functional decline, and death), considered in light of wider evidence which suggests that older people may not achieve functional improvements during hospital and bed-based episodes of care, suggests such reasoning requires critical consideration.

The orientation of acute care towards fast-paced trajectories, managing expenditure by utilising less expensive beds where appropriate, and discharging at the point of safety rather than at the point of achieving optimum function, was experienced as being at odds with an environment which fosters collaborative decision-making and patient and family involvement.

9.3. Implications for practice

The construct of rehabilitation in this setting, mainly as a way to optimise physical functioning, primarily as a professionally-led process headed by physiotherapists, and strongly associated with a movement to a place which may (or may not) facilitate intensity and frequency of professional intervention, has many implications for practice. The social constructionist researcher believes that multiple constructions within the social world are possible although dominant constructions emerge in relation to social utility (Gergen, 2009). It is therefore important to pause on the important question of why is it useful that such constructions of rehabilitation and rehabilitation potential have emerged in this field and what purposes are they serving.

Much of the discussion in this thesis has shone a light on the issues that the construct of rehabilitation as a process to improve mobility, and the blurring of an assessment of rehabilitation potential with an internal transfer, are serving organisations and systems who need to optimise flow and minimise cost whilst potentially failing those who are in need of rehabilitation services. Patient examples of functional decline, limited opportunities for meaningful involvement and the messages of distress communicated in professional extracts are powerful pointers towards incompatibility between desired tenets of rehabilitation and the acute hospital environment. Hammell (2006) suggests that contemporary rehabilitation must challenge assumptions that physical gains represent enhancements in quality of life, and that safety and independence are the desired goals of those living with impairments. She continues that rehabilitation should be more focussed on the endeavour of living, in line with definitions of rehabilitation which encourage attention to holistic needs, adjustment, and interaction with environments.

Fieldwork in this context suggested that rehabilitation professionals recognised that the version of rehabilitation was unsatisfactory for many reasons, and indeed critically, ways of constructing rehabilitation (such as rehabilitation as a different place) were perhaps serving their own purposes to rationalise deficiencies in their own service provision. Durocher et al (2016) suggest that a first step is to notice, document, and have conversations about such dimensions of practice; something where this thesis can contribute to an important and achievable step forwards.

It was noted that, in part due to rehabilitation being conceptualised as a place, and a place outside of the base ward, patients listed for a different place such as the rehabilitation ward, or intermediate care unit, often became less of a priority for rehabilitative interventions in the current place and phase of care. Although implications of this may have been minimised through recent changes in this site to co-locate medical and rehabilitation phases, dissemination of these findings should aim to assist other practitioners and services to recognise when this may be happening. The risks associated with this – including increasing length of stay, increasing likelihood of functional decline, and compromising the patient and family experience of care are significant to note. It is areas such as this where practitioners can aim to influence change without delay.

The interrelated issues of autonomy, patient involvement and collaboration would benefit from attention in practice on many levels. At the level of individual patients, receiving clear information in an accessible way about what rehabilitation may mean and involve and what options for rehabilitation are available, is an obvious and achievable foundation step and would assist in the management of expectations of both patients and families. It is proposed that the simple 4-stage model (presented on page 123) could form the basis of involving patients and families in dialogue about rehabilitation decision-making. It could also provide a framework for documenting reasoning – something which was notably unclear in this setting. Part of this could also include developing a clearer process for obtaining and documenting information about a patient's baseline, which was assumed to be embedded within practice within this context but would benefit from immediate attention.

Alongside this, honest conversations about what older people would like to work towards to enhance their quality of life, how realistic this may be and which services (if any) may be best placed to facilitate these enhancements would again be important steps in moving towards a different version of rehabilitation with less emphasis on assumed or implicit goals and less controlled by professional decisions. The most commonly reported area to improve goal-setting practices suggested by research is to introduce an education element prior to setting-goals, so patients and families understand the purpose of goal-setting and can participate in the process in a meaningful way (Rose, Rosewilliam and Soundy, 2017).

Although goal-setting conversations could happen on an individual level with an older person following an acute admission, there are many valid reasons why this may not be happening, leading to challenges with implementing this in practice. Indeed professionals know that this is a desirable element of a rehabilitative phase of care and simply reminding or restating is unlikely to change the status quo. Once again, there is a salient reminder here that acute hospital care is perhaps not the most appropriate or facilitative environment for such conversations, and that by the time of an acute admission, the older person may not be in the optimum position to engage.

Therefore, a wider and more creative solution could be to develop the model of advance care planning, adopted already in many places for people with life-limiting diagnoses, for older people in general. This has the potential to provide a framework for honest discussion about ageing, including elements such as when bed-based or hospital care may be required, and how individuals would evaluate their own quality of life. This in itself could contribute to moving towards desired central tenets of rehabilitation, tailoring interventions to individuals and placing individual goals at the heart of the process.

Many of these implications are fundamentally linked to incongruence between the orientation of an acute hospital setting, and the provision of rehabilitative phases of care for older people. The biomedical model of illness is recognised as dominating acute hospital systems, sustained by neo-liberal politics of targets and efficiencies for episodes of diagnosis and treatment. However, the biomedical model is increasingly discussed as being fundamentally flawed when considering complexity and chronicity of health and wellbeing needs, with arguments for radical change and a move towards a biopsychosocial model growing in strength (Wade and Halligan, 2017).

Whilst recognising that much of this is not easy to change or influence, dialogue that recognises this incongruence and the way that the practice of rehabilitation professionals is being moulded by this is again, an important point of action and reflection. Occupational therapists and physiotherapists – alongside the professionals they work alongside - need support to recognise how their roles have been shaped by contemporary organisational drivers, to recognise the professional artistry that has evolved in response to this and to continue to work towards practice which is aligned with the core values of their professions. Both professions can contribute to leading and championing local change which can potentially inform wider reform. Although pertinent across both groups, this was felt to be particularly salient for occupational therapists who would benefit from developing ways to promote their identity and value in this acute hospital context – an issue noted in this setting but echoed in wider research (Britton, Rosenwax & McNamara, 2015; Wilding and Whiteford, 2009).

The ethical challenges and distress experienced by occupational therapists and physiotherapists as part of their everyday roles – striving for ideals of rehabilitation, acting as gatekeepers for rehabilitation resources, and providing rehabilitative interventions in the context of highly pressured services – provided important insights in to the realities of practice. Interestingly, although this was implied during earlier stages of fieldwork, this was mainly communicated during interviews with health professionals. This suggests that the creation of reflective spaces helps to give voice to such tensions and realities. The use of clinical narratives, reflection and debriefing have been discussed as ways to manage the effects of ethical tensions, with the suggestion that such processes will increase clarity, help to proactively recognise ethical issues before the demands feel unmanageable, and recognise sources of support (Erler, 2017). Whilst taking time out for reflection on ethical issues may feel counter-intuitive within busy acute environments, it is seen as an essential part of professional practice and one which has direct links to quality of patient care. Managers and educators also play an important role in creating cultures of reflective practice and preparing professionals with strategies to manage ethical challenges in practice.

Space and time for reflective practice could also link to a stronger emphasis on evidence-based practice amongst rehabilitation professionals. Although many elements of practice and decision-making appear to have been linked implicitly to evidence, explicit articulation of such links were notably absent. More explicit use of evidence to underpin dialogue with patients (for example evidence informing positive outcomes or those most likely to benefit), or to encourage new ways of working (for example use of goal-setting approaches or frailty measures) could lead to important service improvements. Equally, collation of evidence to oppose the organisational rhetoric of aiming for safety rather than optimum function could help to challenge unhelpful discourses and assert professional autonomy.

Whilst reflective and evidence-based practice at the level of individuals and teams is an important strategy, practitioners would benefit from wider support from professional bodies. Ethical codes of conduct could be strengthened to provide guidance on the professional role in making sustainable decisions within the realities of competing and finite resources, to provide constructive support to practitioners in their gatekeeping roles, and to more directly situate professional reasoning in a context of collaboration and partnership with service users.

Recent WHO communications – for example 'Rehabilitation in Health Systems' (2017) and 'Rehabilitation 2030 – a call for action' (2017) - have gone some way to provide an international reminder of the importance of rehabilitation in meeting the contemporary health and social care needs of global populations. However, the emphasis is mainly on the challenges faced by low- and middle-income countries where health investment has been historically poor. Although these challenges are undisputable, the localised reflections above, coupled with the challenging landscape of rehabilitation for older people in the UK, suggest that there are many similar and many different questions facing practice closer to home. The recent NICE guidance on 'Intermediate care Including Reablement' (2017) goes some way to address this although the guidance on rehabilitation in acute care for older people could be a specific area of focus for policy-makers and strategists.

Due to the significance of the concept to the research aim, I return to the term 'rehabilitation potential' and it's place within professional discourse. In basic terms, the concept was not explained to patients, was linked to ethical distress for professionals and was recognised as ambiguous, subjectively interpreted and poorly documented. It is therefore a logical outcome to question the relevance of the term at all. Rather than ongoing rumination on the term rehabilitation potential and its associated evaluation, emphasis could simply be placed on honest communication (including documentation) to collaborate about what people want and need to be able to do, whether all parties think such goals are realistic, and which services are available (if any) to work towards any goals. Whilst influencing some of the wider implications for practice may feel overwhelming or unmanageable, this simple conclusion could lead to meaningful cultural change.

9.4. Strengths and Limitations of the current study

The immersive ethnographic methodology, placing importance on the social construction of meaning and subsequent decision-making, has enabled examination of the concepts of rehabilitation and rehabilitation potential within the context in which they are formed, and is proposed as a major strength of this study. This is in comparison with wider literature on the topic which has examined the issues through methods which encourage retrospective analysis or discussing the concepts outside of the everyday influences of healthcare practice. An additional strength includes the intentional focus given to occupational therapists and physiotherapists, whose practice and identity is interwoven with rehabilitation ideology and yet where a specific focus and emphasis within research enquiry relating to rehabilitation potential is relatively under-developed. Finally, the importance placed on examining these issues in relation to the non-uniform pathways and heterogeneous population of older people is seen as another important strength of the study and one where extensions to knowledge and understanding are of vital importance.

Limitations of this thesis must begin by acknowledging criticisms of ethnography as a methodology with those key features often presented as strengths, illustrated as weaknesses by others perhaps in equal measures. For example, for some the principle of honing in on focussed areas (in this instance a ward and a small group of professionals and patients) can be reflected as gaining in-depth understanding of a localised context whilst for others it represents small-scale research which cannot be generalised. Equally, the ability to use flexible data gathering methods is highlighted as an ability to use all methods available to throw light on emerging and salient issues, whilst for others this is seen as unscientific, difficult to replicate and heavily open to researcher bias. And with all forms of qualitative enquiry, it is recognised that data gathering, analysis and subsequent interpretive discussions are my own constructions which are open to challenge. Whilst not contesting that these issues represent real limitations, I have discussed and appraised many elements of decision-making in relation to the choice of method in previous chapters and presented strategies to enhance quality and rigour.

One of the key defining features of ethnography is proposed as prolonged periods of fieldwork and observation (Savage, 2000). Although data collection spanned approximately 13 months, actual points of data gathering involved much shorter time scales with an introductory first phase of 2 weeks, phase 2 fieldwork lasting approximately 8 weeks, and phase 3 involving 5 in-depth interviews within one month and I do feel that longer periods for all phases would have enabled further and deeper understandings in all areas. Also, time gaps between phases perhaps meant that opportunities were missed to gain detailed understanding of some of the organisational changes which took place during this time and potentially changed relationships with participants. The reality was that pragmatic factors of time and workload played a significant part.

Another limitation was the limited representation of the patient perspective in this research, something discussed in earlier sections. Meaningful service user involvement represented a challenge on a number of levels – both through my limited ability to collaborate with patients and carers in a meaningful way as research participants, and through the limited involvement of service users in the wider construction of the research. An important element of my planned activities included informal and formal opportunities to talk to patients and families about aspects of rehabilitation and rehabilitation decision-making. However in reality, I quickly became aware that these concepts were not obviously being discussed with, or translated for, patients (discussed in more detail in previous chapters) which resulted in discussion about these elements being problematic. Linked to this, my interactions with patients instead became characterised by short and superficial interactions asking what had happened on a particular day or asking if anything had changed. In a recent descriptive study of interactions between patients and health professionals the median interaction was just 36 seconds (Barker et al, 2016) and I was perhaps also being influenced by dominant ways of working in this setting. Also, regarding more formal communication, I had proposed to carry out individual interviews towards the end of an episode of care although these were either declined (in two cases) or were not possible due to patient death (in three cases – summarised in table 2 on page 77). For some of these reasons, the patient and family voice and experience was perhaps under-represented during phases of fieldwork. However, the body of knowledge presented in this thesis would have been richer and more deeply layered with improvements in this area.

Some areas of focus did not explicitly emerge until later stages of analysis, such as the far-reaching influence of the biomedical model of illness and the ethical distress experienced through systemic challenges in practice such as gatekeeping responsibilities. It could be argued that this in itself represents a strength of the research, that I remained open to new perspectives and emerging themes. However, I am also aware that opportunities were missed, particularly during in-depth interviews, to explore these issues more explicitly with those experiencing them.

9.5. Dissemination of findings

The findings of this study are most obviously relevant to those within the field, therefore the first stage of dissemination will be to share the research findings with those who participated in this study. Patients and relatives who indicated an interest in receiving follow-up information will be sent a summary of findings. I will also work with the clinical teams involved to identify the best way to disseminate and discuss findings – including the offer of written summaries, presentations, and reflective workshops.

In my role as an occupational therapy lecturer, I am also keen to identify ways to disseminate findings both within pre-registration and post-qualifying education. Using research findings to prepare students and professionals for the realities of decision-making in rehabilitation within acute care, alongside encouraging critical discourse to constructively challenge models of practice and service delivery, could provide important opportunities for professional and service development.

I have also been encouraged by the interest of my immediate supervision team and the interested voices of wider networks in the knowledge which has emerged from this project. Specific topics from the research findings which could potentially become the focus of future publications or conference presentations include the meaning of rehabilitation in acute hospital contexts and working towards justice for older people in acute care. Learning from the process of undertaking this research could also be disseminated, including sharing experiences of being a novice ethnographer in an acute context and challenges to meaningful patient and family involvement in research situated in acute hospitals.

9.6. Recommendations for future research

This research focussed on the meaning of rehabilitation potential as influenced by the context in which it was constructed, and the evaluation of rehabilitation potential as experienced and constructed by occupational therapists and physiotherapists in their daily practice. It did not examine effectiveness of any rehabilitation interventions, or whether judgements about rehabilitation potential were accurate. Research to examine efficacy of interventions and which patients will benefit most are questions of ongoing importance and priority. This is particularly significant when considering that even in contemporary policy examples – such as the NICE Guideline on Intermediate Care and Reablement (2017), many recommendations are underpinned from research in to specialisms such as orthopaedics and stroke.

Work to develop and evaluate criteria or assessments which help to move towards more objective and standardised professional decision-making when considering the allocation of rehabilitation resources for older people is another related area of interest. Another area of note is research to evaluate different models of rehabilitation for older people from the perspective of the patient or service user, which could be particularly relevant within this local context where services are being reconfigured.

Although advance care planning is proposed as a process for any person to have prospective discussions about future health and care needs with family members and health professionals (Sudore et al, 2017), in practice the focus tends to be on discussions about life-sustaining treatments, and much of the existing literature focuses on particular clinical groups, often with established life-limiting conditions, such as Dementia or Cancer. Use with healthy populations in general, and more specifically with well older people who can still communicate their wishes and goals is less understood and has been challenged due to the changing nature of preferences and needs during episodes of illness or when adjusting to new disability. However, an advance care planning model which focuses on issues such as wishes for hospital admissions, goals for rehabilitation and realistically, moving forwards, which services people would wish to pay for, would add significantly to current understanding and would benefit from research to assist with development and evaluation. Whether the label of advance care planning has now become synonymous with end of life care and terminal illness requires critical consideration when considering how this framework could support discussions and decision-making amongst healthy populations.

Rehabilitation as a place was noted by this research, in the sense that rehabilitative phases of care were often initiated when a patient was moved to a ward or bed outside of the base ward. Practitioners also communicated a belief that facilities were related to the creation of a rehabilitation ethos and the interaction with physical space could be seen to influence elements of role development and decision-making (for example the time spent on the base ward by physiotherapists in comparison to occupational therapists). Hospitals have been identified as ‘extraordinary places’ due to being outside of everyday geographies which are associated with catastrophic events (Kontos et al, 2015; p120). Research to understand the influence of physical space, built environment and facilities on the ethos of rehabilitation for older people, rehabilitation roles and decision-making could provide ways to develop ethnographic understanding on these topics. This is particularly significant in this local hospital site and in acute hospital systems in general, where functions of wards are frequently reconfigured (supported by the extract on page 155 ‘when we were a rehab ward’), although physical environments often remains static.

Although professionals shared their feelings of ethical distress, the sharing of consequences and strategies were perhaps less obvious and forthcoming. In simple terms, this could be because I was not drawing focus to this issue or asking direct questions during fieldwork or interviews and this could become a primary focus of future research. However, another reflection could be that whilst practitioners may be able to recognise and describe ethical dilemmas and distress, they may lack the vocabulary to articulate a deeper analysis of the situation, or may struggle to acknowledge some of their responses to minimising tensions and distress (Carpenter, 2010). Participatory research methods to use and evaluate approaches to assist with this could again be an interesting area of further enquiry.

Alongside this, because of the breadth of the current study, other areas emerged as pertinent although received limited focus within the thematic analysis and subsequent discussion. Understanding the labelling of patients was an interesting, yet small area highlighted within the findings. Equally, hierarchies within rehabilitation teams and the impact on rehabilitation decision-making, and the professional identify of rehabilitation professionals were both smaller themes in a broader presentation of research findings and are again areas of significant interest which could receive more direct and detailed focus in future research.

9.7. Final reflections on the research journey

At different points in the writing of this thesis, I have reflected on the concept of ‘self’ and how my own experiences were shaping the direction, and indeed integrity, of this research. It is therefore important to conclude with my own final reflections on this personal journey.

One of my main challenges was the journey through ethical approval; balancing the unpredictability and serendipity of ethnography with clear and planned processes for the purposes of research governance was a difficult reality. I can understand why this may discourage ethnographers, and particularly novice ethnographers, from planning this type of research within the social spaces of health and care environments. During the process of ethical approval, I was encouraged to reconsider the involvement of people who may lack capacity to consent to participate. I continue to reflect that strengthening my understanding of involving people who lack capacity in research in order to gain ethical approval for this element was one of my main achievements and provided some of the richest learning throughout the whole journey. The reality of this study was that this deep planning and learning only applied to the involvement of one patient, although I hope the learning will add long-lasting value to my research career and journey in its entirety.

I have been driven from the outset by a desire for this work to be useful and interesting, a motivation recognised within social scientific research (Michael, 2012). I have frequently questioned whether this could ever be the case: with the context so specific and localised; my interest in a population who, it could be perceived, receive less than favourable attention; and my interest in smaller professional disciplines perhaps at the exclusion of other more dominant groups. Something I have only reflected on at a late stage is that, throughout the research journey, I have managed to communicate to others that the work *is* useful and interesting – both as part of the doctorate approval and progression processes, but perhaps more importantly, to participants, stakeholders and gatekeepers.

My supervisors played an important role in continuing to reassure me that the work held value, interest and utility. But alongside this, they also encouraged me to think critically about my judgements and assumptions about what I thought to be useful and interesting. Supervision, particularly during phases of fieldwork, and then subsequently during data analysis encouraged me to look and relook at things I had perhaps disregarded as of little interest. More realistically, I had perhaps begun to think of things as failures, deviances, or incomplete pictures and may have been tempted to bury them or pass them by. Supervision meetings while I was active within the field, and then sharing anonymised fieldnotes and transcripts were central to this process. I will certainly remember and apply this learning in future roles within research teams and when contributing to research supervision.

I feel I experienced ongoing tension between theoretical and philosophical research principles and delivering real-world research. Such examples are reflected in earlier sections: for example my stated commitment to immersive research methods although my actual short, and sometimes abrupt, research interactions; and my commitment to public and patient involvement although the frustrations in achieving this in a meaningful way. This second example has been particularly difficult to reconcile, particularly during the process of engagement with critical theory emphasising the need for collaborative approaches to rehabilitation. I feel I was guilty of assuming that there would be recognised ways to facilitate public and patient involvement within the Trust and I would be able to link my own involvement agenda seamlessly to this. However, evidence suggests there are challenges to involvement at all levels – not just at the level of individual researchers - and in future research I will aim to establish much clearer mechanisms for meaningful involvement at the outset rather than making assumptions that established mechanisms will either be effective or indeed exist.

This personal experience of translating theoretical and philosophical principles in to the real world is perhaps mirrored in the experiences of participants within the field. That is to say, practitioners expressed theoretical and philosophical principles and values relating to rehabilitation and rehabilitation decision-making although expressed frustrations and constraints with their ability to enact these principles and live out these values. In this sense, I feel a sense of empathy with how the realities of an acute hospital system can constrain practice – irrespective of whether this practice is research or clinically orientated.

Looking ahead, I feel this can potentially provide me with invaluable learning for some of the challenges of my research journey which are yet to come. When reporting and disseminating ethnographic research, researchers are often perceived to have been in a position of privilege and power and are then seen to be commenting on, and sometimes judging, a social world they have only experienced for a short time and potentially in a one-dimensional way. However, I feel this essence of shared experience can offer me an important starting point and act as the foundation for a collaborative partnership with practitioners when looking to future practice development and opportunities for research.

9.8. Final Conclusions

In conclusion, this study has prioritised understanding rehabilitation pathways for older people as a core issue for research and professional dialogue, recognising the vital contribution that such pathways make to the health and wellbeing of older people as they recover from episodes of ill-health and as they experience and adjust to increasing frailty. Specifically, the research has examined the meaning of rehabilitation and rehabilitation potential in relation to older people in hospitals, through an immersive methodology to examine the concepts within the social, temporal and organisational context in which they are constructed. Evaluations of rehabilitation potential for older people are primarily understood in relation to the likelihood of physical improvements and the evaluation is often driven by well-intentioned paternalism, both of which are linked to the dominant discourse of acute hospital settings. Despite being a regular and taken-for-granted part of professional discourse, reasoning is poorly articulated both within professional-patient and inter-professional interactions and poorly documented within clinical records. Dissemination of the research findings will aim to highlight such issues as important areas for service and professional development.

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Appendices

Appendix 1 – Phase 3 Semi-Structured Interview Schedule

Introduction

- Revisit consent
- Revisit purpose of study and recap what has been done so far
- Discuss the format of the interview – pose some broad questions to understand your ideas and then share some reflections from my experience within your services and ask for your further thoughts and interpretations in relation to these areas

Recap of Professional Role

1. My area of interest is the concept of rehabilitation potential, and in particular, the decision making process and different people's roles within those decisions. But before, we start talking more specifically about decision making and roles, I wonder whether you could start off by **describing your role in general** (probably the role you were doing at the time if this has since changed) – **in your own words**. This will be helpful context for the later discussion.

Meanings

2. **In your words, can you describe what you mean by rehabilitation?**

   Further discussion points…

   From my observations, when talking about rehabilitation, many people were relating this to a process to facilitate improvements in mobility. Do you think this is the case?

   Rehabilitation also was often referred to in relation to a place (e.g. someone being listed for or transferred to rehabilitation) – again, do you think this is the case?

   Finally, in relation to the meaning of rehabilitation – it also seemed easier for professionals to describe when they didn't think it was happening – does this fit with your experience?

3. **In your own words, can you describe what you mean by rehabilitation potential?**

Further discussion points…

Again, from my observations, rehabilitation potential seemed to link mainly to the potential to get back to baseline mobility – does this fit with your experience?

However, there were examples of other meanings – for example, the potential to influence discharge outcomes (e.g. to get home, or to go to res care rather than nursing care), the potential to be safer (e.g. with equipment), or potential to reduce dependency on services (e.g. go home with a minimal care package rather than something like 4x visits). Again – does this reflect your experience?

What do you think the impact, if any, might be of these different interpretations?

At one point during my time within your wards, someone compared rehabilitation potential to how we have now come to think of mental capacity – in that we now think of mental capacity as being decision specific, and we could think of rehabilitation potential being goal specific – that is being specific about potential to do what? What do you think about this reflection?

Decision Making

4. **What is going through your mind when you think about rehabilitation potential?**

Further discussion points…

Some of the things I noticed included:
- Clinical features (co-morbidities, cognition, mood, nutrition)
- Other individual features (baseline function, home environment, social situation)
- resources
- Assessment through engagement during the rehab process (e.g. carryover, consistency, motivation/engagement)
- your professional desire to give people a chance

Does this reflect your experience?

Do you think some of these influences are more important than others (could prompt with a question to identify 3 most important?)

5. **Alongside making a judgement about whether someone has rehabilitation potential, you are also thinking about the pathway that might best meet their needs (e.g. the ward, or the service). Is there anything additional going through your mind at this point?**

   Further discussion points…

   Some of the things I noticed include: where can manage any risks, and the availability of resources – does this fit with your experience and are there any examples that would help me to understand these things further?

   The opinion of the receiving service also presented as significant – professionals asking themselves what the staff at ***, or the community ** team would think about the appropriateness of the referral. Do you think this is the case?

6. **How would you describe *your* role in decisions about:**
   Rehabilitation potential
   Pathways

   Further discussion points…

   One of the things I noticed was that, particularly in the early stages, Physio seems to have an important role in these decisions. Does this reflect your experience? If so, why do you think this may be the case?

7. **To what extent do you think the wishes of the patient and family influences these decisions?**

   Further discussion points…

   How would you describe your role in this area of decision making?

   One of the things I reflected upon was that perhaps patients and families are not as involved in decisions about their own rehabilitation potential and their pathways as perhaps organisations (or policy drivers) would like to think they could be. Does this reflect your own experience? If so, why do you think this might be the case?

Also, the professionals I worked alongside seemed to becoming very accustomed to working with very frail, and often cognitively impaired individuals and I reflected that perhaps talking to families about decisions – rather than directly to patients – may be becoming more of the default position. Do you think this could be the case?

Appendix 2 – Sample Observational Checklist

Record Date/time/place/type of event

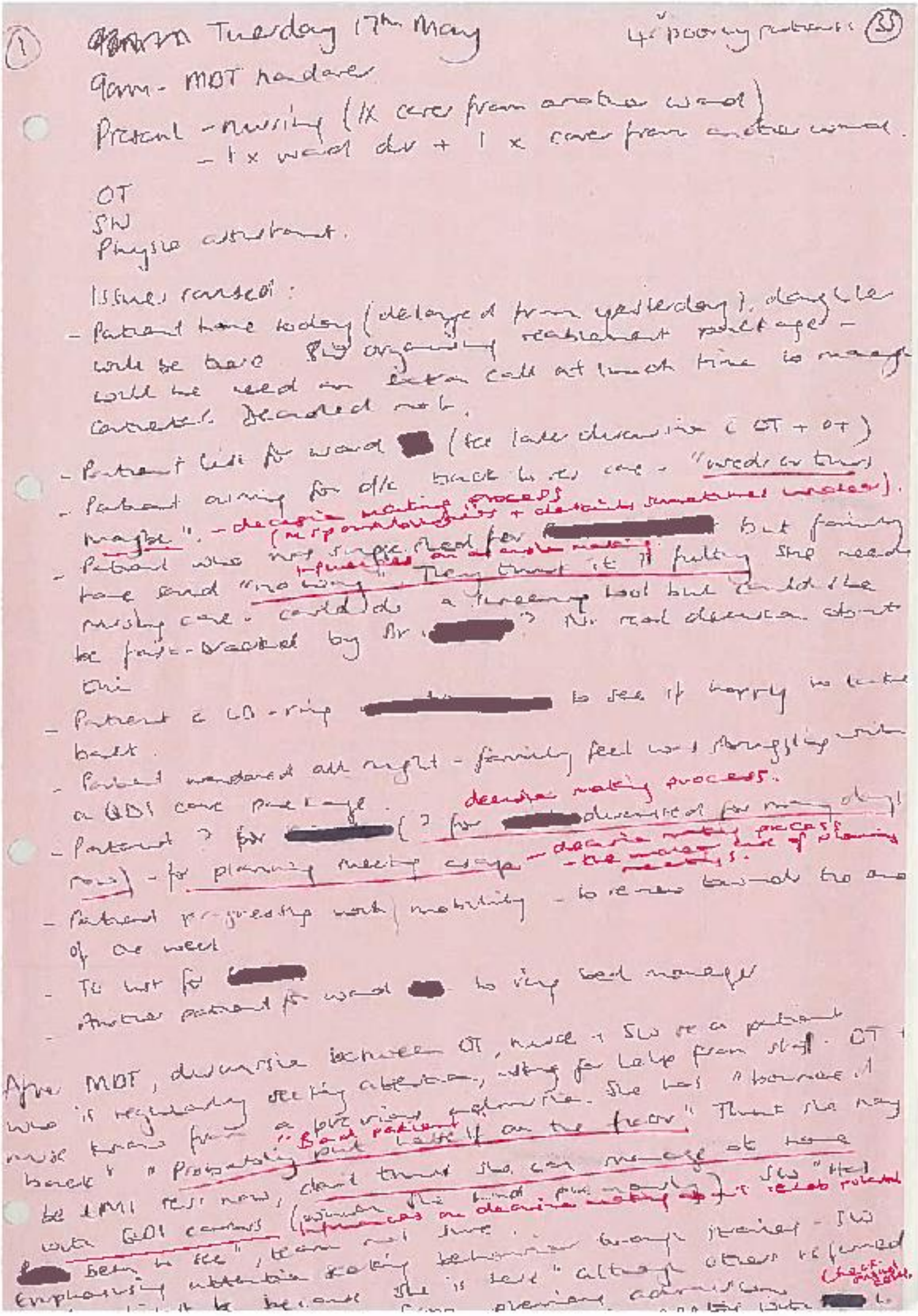
Adapted from Spradley (1980):

- Space – layout and points to note about the physical setting (diagram if helpful)
- Actors – names and relevant details of people present
- Activities – description of the various activities of the actors
- Acts – specific individual actions or behaviours
- Events -
- Time – sequence of events
- Goals – what were the actors trying to accomplish – note explicit goals (e.g. purpose of meeting) and other observations about motivations or agendas.
- Feelings

Other considerations:

- Interactive patterns
- Language
- Non-verbal behaviours
- Ideational elements – anything that reflects beliefs, attitudes or values
- Broader contextual/social information
- Human needs
- Other observations

Appendix 3 – Sample from Fieldnotes (including annotations and memos)



① ~~9am~~ Tuesday 17th May   4 poorly patients ㉟

9am - MDT handover

Present - nursing (1x carer from another ward)
- 1x ward dr + 1 x carer from another ward.

OT
SW
Physio assistant.

Issues raised:
- Patient home today (delayed from yesterday), daughter will be there. [illegible] organising reablement package - will we need an extra call at lunch time to manage continence? Decided not.
- Patient listed for ward [redacted] (for later discussion c OT + OT)
- Patient aiming for d/c back to res care - "weeks or days maybe". - decision making process (responsibilities + details sometimes unclear).
- Patient who not suitable for [redacted] but family have said "no way". They think it is putting her needs [illegible] could do a [illegible] tool but could she have nursing care - could do a [illegible] ? No real discussion about be fast-tracked by Dr [redacted]. influenced [illegible] another [illegible]
- [illegible] [redacted] to see if happy to take
- Patient c LD - ring [redacted] back.
- Patient wandered all night - family feel was struggling with a QDI care package. decision making process.
- Patient ? for [redacted] (? for [redacted] discussed for many days!) - for planning meeting asap - decision making process - the wider lack of planning meetings.
- Patient progressing with mobility - to review towards the end of the week
- TC lost for [redacted] - to ring bed manager
- Another patient for ward [redacted]
-

After MDT, discussion between OT, nurse + SW re a patient who is regularly seeking attention, asking for help from staff. OT + nurse known from a previous admission. She was "a bouncer" [illegible] That she may "Probably put herself on the floor" "Bad patient" "Probably don't think she can manage at home" SW "Had be EMI res now, (... the kind [illegible]) (influences on decision making) [illegible] relationship with QDI carers" [illegible] - SW [redacted] been to see", team not sure [illegible] behaviour [illegible] others referred emphasising attention seeking as [illegible] she is [illegible]" although [illegible] previous admissions [illegible] [redacted] [illegible] (check original data)

Appendix 4 – Clarifying the analytical position – adapted from Braun and Clarke (2006) and used to discuss data analysis within supervision

Before outlining the stages and steps involved in thematic analysis, Braun and Clarke suggest the researcher must clarify their position with regard to values, assumptions and decision making and answer a series of analytical questions:

- What counts as a theme?
- Is the analysis inductive or theoretical?
- Will the analysis be identifying semantic or latent themes?
- How does the analysis align with epistemological assumptions?

Presented as the last in their series of questions, I feel the question of how thematic analysis aligns with epistemological assumptions is important to address first. In the example of this data analysis, the research is aligned to a social constructionist epistemology which aims to examine the ways in which events, realities, meanings and experiences are the effects of a range of influences within the particular social context. It is therefore not the goal of the analysis to focus on individual motivations or the link between meanings and individual experiences.

Another question that any researcher utilising thematic analysis should reflect on, and understand their own response to, is ‘what counts as a theme?’. The researcher should bring their awareness to themes being prevalent across the entire data set and as entities which capture something important in relation to the research question and aims. In addition, Braun and Clarke suggest is it important to consider the purpose of analysis and ask whether it represents a rich description of the entire data set or a detailed account of one aspect. In the case of this research, it is my intention to provide a full description of the entire data set, again perhaps at the expense of presenting individual cases. This is again, something that an alternative approach such as narrative analysis may have promoted.

A further question from Braun and Clarke is whether the analysis is inductive or theoretical in nature. By this, they suggest that an inductive analysis is a ‘bottom-up’ approach, not driven by the researcher’s theoretical interest and potentially bearing no resemblance to the questions asked of participants or indeed the researcher’s objectives. In simple terms, it is a process of coding without trying to fit the data into a pre-existing coding frame. In contrast, an analysis of a more ‘theoretical’ nature aims to map the data to specific research aims and questions. In relation to this research study, my position here has perhaps been a little more unclear to define. I am open to the emergence of themes outside of the original research aim and objectives, although recognise that it is perhaps unrealistic to free myself from some of the theoretical perspectives which motivated the project and were needed to research existing literature and gain necessary approvals to progress. I have therefore conceptualised a spectrum between inductive and theoretical positions, with this project proposing to adopt a mid-point position on this continuum aiming to maximise opportunities from both perspectives.

A final question according to Braun and Clarke, which requires reflection and clarification prior to data analysis, is whether the researcher will be identifying semantic or latent themes. At a semantic level, the researcher is primarily identifying themes within the explicit or surface meanings and the researcher is not looking much beyond what has been said or has been written. In comparison, a latent theme instead looks to identify or examine underlying ideas, assumptions and conceptualisations that are theorised as influencing the semantic content of the data. Again, as what has been said and written by participants is only a small part of a wider data set which captures researcher observations of the physical, social and temporal environment and context, the analysis of data set for this project presents as aiming to identify latent themes, which is in alignment with the suggestion that this approach tends to grow from a constructionist paradigm (Burr, 1995).

Appendix 5 – Example from Coding - Code: ‘Meaning of Rehabilitation’

Examples from Fieldnotes where the term ‘Rehabilitation’ being used/described/interpreted

Physio discussed the ‘ideal’ of a 24-hour approach to rehabilitation – for all staff to be working towards rehab goals. He would like to implement training with assistant nursing staff so they could take for walks, practice exercises. Instead, he feel that different people only have contact with patients for their role (e.g doing observations). Implication that this 24-hour approach isn’t happening on this ward	Page 9
Patient who is listed for *** (cog rehab unit), by the time there is a bed available, may be able to go home from here. Rehabilitation perceived as a place?	Page 19
Going to rehab often gets sold as somewhere they go to for intensive therapy but in reality, it might not be that different	Page 20
Go to ward ** for rehab	Page 20
SW using terms rehabilitation and reablement interchangeably	Page 21
Other services dealing with rehabilitation issues – e.g. refer to POAS for decreased motivation	Page 30
Rehabilitation linked to improving mobility PT to nursing staff - Encourage mobility as much as you can	Page 32
During discussion with bed managers: “If a patient is moved to another elderly bed on a base site, the patient comes off the list for rehab”. Rehabilitation as a place rather than an approach to care	Page 42
During an MDT meeting, Consultant mentioned “Query for rehab” – as if not already happening there.	Page 65
Description of what rehabilitation is provided at the intermediate care unit – some aspects are less than the provision in hospital – for example, weekend therapy	Page 68
Discussion with intermediate care OT – people refer patients here for rehab although it is more about discharge planning than rehab.	Page 70
OT intermediate care unit – we try to look at rehabilitation beyond just mobility – e.g. get people to manage own medications, catheters etc However, this can be limited by time constraints	Page 70
OT intermediate care unit – they are a rehab service although feel the dependence of patients has changed i.e. they are more dependent. Linked to rehab ward who also feel they get patients that other services don’t know what to do with	Page 71
OT – ward ** “Would like to be able to do ‘rehab’ but does not feel able to	Page 83
OT ward ** – told story of someone she is working with – currently sleeping in a chair, had set goals to increase length of time spent in bed, had some difficult conversations – “you’re not doing this for me, you’re doing this for yourself” (but link to OT thinking she’s not doing ‘rehab’	Page 83

Physio ward ** – patient 1 – trying to improve consistency with mobility	Page 84
Patient 2 – 4 days after admission, plan in medical entry includes medical actions and "physio" (i.e. physio are the providers of rehab at this early stage)	Page 88
Physio ward ** re: patient 2 – Unfortunately I've not seen a lot of her so far (e.g. this ward not a place for rehab?)	Page 93
Patient who has had 7 ward transfers during the admission and decided to keep on ward ** at the moment. Consultant "There are still issues around his Parkinsons, continence, skin integrity, and to manage his posture/prevent contractures. There is a lot the team can do for quality of life" – wider interpretation of rehabilitation	107
Consultant "best rehab tends to be at home in terms of doing stuff"	107
Training a patient to empty catheter and stoma bags	107
Ward ** Physio about patient 2 – sometimes you think, is it better to get someone home as quickly as possible even if it does mean them being hoisted and perhaps not reaching their potential or is it better to keep them and just keep…you know…to work on what and to try and get them better…if we could keep her a bit longer.	134
"Waiting for rehab as he's still assistance of 1 for mobility"	141
Ward ** staff "people using hospitals like respite"	148
Patient 2 notes – from MDT "More time with OT/PT" – this may be what team think of as rehab but no OT involvement to date	156
Expectations of rehabilitation – ward ** sometimes get anger from relatives if they have unrealistic expectations	160
Junior PT "That will have given her another week of rehab"	170
Ward ** Physio re patient " Feels this patient could make good progress with a period of intensive rehab but don't' feel we have that here". Wish they could do passive movements a few times per day and then give him practice with the standing hoist a couple of times per day but that just cant happen	178
Ward ** Physio – when discussing prioritisation – if we see these patients 2/3 times per day and see these patients less…to direct the resources to those where they can make the best gains instead of just trying to see every patient every day. But that seems at odds with the organisation who want them to see more of the quick patients to turn them around.	178
Discussion with physio about ** closing – thinks this ward will become more like a rehab ward	183
"Can come back in for rehab once fracture has healed"	183
"too sleepy for physio"	185
Asked patient 5 if he was aware why he had gone to ward ** – "to get stronger".	199
Patient 5 – using pedals.	217

Examples from Interviews where the term 'Rehabilitation' being used/described/interpreted

it's a multi-disciplinary…em…and goal-led…that's what I tend to think…that if we're looking at proper rehabilitation then…em…it	Interview 1 pg 2

should be that we're working with…the patients and with their families as much as we can to all be achieving the goals that the patient wants and that we want as well. So it could be…even, you know rehabilitation includes lots of things…it's not…from a physio point of view, as I say, we tend to always be thinking are they transferring, can they get in and out of bed independently. But from an Occupational Therapist, then rehabilitation is much more about things like personal care and, you know, managing things at home. Which obviously we do…that's why we work with them…Em. But there's…you know, a lot of different areas to rehabilitation. And also…rehabilitation…em…isn't just the physical side of it as well…there's the cognitive side of it and the…em…I think a big part of rehabilitation is…em…put it this way, rehabilitation works a lot better when people want to do it and they've got motivation to do it and cognitively they're able to understand why…em…we're doing the things that we're doing.	
so, we need to have goals…but within the team, and that's the whole team, it always does seem to go down to right, transfers, mobility, that seems to be where everyone hones in on	Interview 1 pg 3
But the rehabilitation shouldn't just be about those things, it should be…and this is what we're trying to introduce…identifying rehab patients and things like em…and this is one of ** things…he's doing a course and…Right, so this is a rehab patient and they don't need to be washed and dressed, you can just give them a bowl and just see what they can do. That's all part of the rehab. Em…they shouldn't have a commode next to their bed, they should be walking…because that's all rehab. But I do definitely think that people think oh…walking…em…are they transferring…that's the rehab. Em…and I think that…em…it's a hard thing to get away from.	Interview 1 pg 3
….I mean the rehab can take place anywhere but it's that…they're waiting for (rehab ward), they're waiting for rehab. And I think that things have changed now because we're trying to be much more rehab focussed on the wards because we don't have as many rehab places. So we are still sending people to rehab	Interview 1 pg 3
Em…where, it would be, oh they are waiting for rehab so we don't really need to see them. Em…because…yeah…definitely, that has happened. And I think that em…it was something that we constantly tried to address on ** because, that's the worst thing to do. Because sometimes the can be waiting for quite a long time	Interview 1 page 4
I think we all want this ideal text book thing…you know, goal-led, get the carers, get the family members, get the patient, do it all together. But it's not always as easy as that. Unfortunately.	Interivew 1 page 7
we've got the community rehab team as well, I don't know whether you've heard of them. That's a new…again…it's completely new. And they…em…are basically…when the ** closed down the teams were made up of support workers who worked at the ** so they've all got a really good background of rehab. The problem that we've got with that team at the moment is that it doesn't have any kind of physio that's…em…connected to the team. So at the moment we're not using them that much from the hospital.	Interview 1 page 10

as I keep saying, it is an MDT approach but I think, the focus is often on *how are they transferring, how are they mobilising,* so then that immediately then comes down to us.	Interview 1 page 12
sometimes more than once a day, several times a day	Interview 1 page 12
And he was absolutely livid because he said 'I was told that my mum was coming to this unit to get 2 hours of physiotherapy a day…and what's happening…she's not getting anywhere near this…blah blah blah'. Now his mum was in her nineties and was really quite frail and you think…well how could you possibly expect that your mum could cope with 2 hours of physiotherapy a day. Because that's just completely unrealistic	Interview 1 page 13
I worked on ward (rehab ward) which was seen as supposedly, a slow-stream rehab ward. Em…I think I probably would have described it more as 'we don't really know what to do with this patient…there's a lot of complexities…we'll send them to ** because they'll have more time to sort them out'	Interview 2 page 1
The physios did more rehab, because there was more physio staff on the ward	Interview 2 page 1
sort of everyday for about 2 weeks	Interview 2 page 1
So then I ended up getting shouted at because people hadn't got the moving and handling plans done and hadn't had their site visits done because I'd been doing *proper rehab*	Interview 2 page 1
you might have rehab with a younger person that takes you half an hour, forty minutes…and the same rehab session with an older person might take you the entire morning. So, you're starting at half 9 and finishing at lunch time, and obviously that gives…I think…if you have twenty…I think it was 29 patients I had…you know, you have to try and balance what's happening with everybody	Interview 2 page 2
Em…for me rehabilitation is somebody getting back something that they've lost. So if they've had an ability before…em…then…my aim, if I was rehabbing them, would be to try and get them back to that point to where they were before. So if they've dropped 3 points down a scale, I'd be trying to get them back up to their original baseline point	Interview 2 page 2
we're being told we're not allowed to use that terminology now, we're not allowed to say we're getting people back to baseline. It's all about what we can do to get them home safely	Interview 2 page 2
because I think mobility is quite key in terms of all of the other activities of daily living for the majority of people, [mobility] is their number one priority of being able to manage something themselves I think it really is the cornerstone of everything else going on.	Interview 2 page 3
I do suspect that there was times when it was probably used more along the lines of…this is going to buy me some time	Interview 2 page 3
Because at the end of the day, they're in hospital because they're poorly so they probably don't feel 100%. Like, how many times would you go out for a run if you had a cold and felt crap…so…and that's what we're essentially asking somebody who's in their 80s to do is get up and have a little jog down the	Interview 2 page 12

ward. And they're maybe in pain and they're tired and they haven't had a good nights sleep because the person in the next bed kept trying to get in to bed with them. And then we're going, we just want to walk you over here, and they're just like…'go away…I just want to sleep today'	
So, if they still need some medical treatment to be in hospital for they're a green patient. If they're still needing physio they're a green patient, but then if they're waiting for OT then they're red	Interview 2 page 17
So…rehabilitation to me is looking at an original…I think the word is now banned in the hospital…baseline as to where the patient was functioning prior to coming in to hospital. And then…working…obviously after the medical issues have been dealt with…working towards getting them back to that level of function that they were previously at. Em…obviously sometimes it may not be…we may not be able to get them back to that baseline so that functional level would drop down. So therefore, you're rehabilitating back to their maximum potential. Em…and…that to me in a nutshell is really what rehabilitation is about	Interview 3 page 1
people think that the major thing that people need to be able to do is mobilise. I'm not always sure that that's the case	Interview 3 page 1
A lot of people get told at (emergency hospital), oh you're going down to the base site for intensive rehab and we've got a bed of…28 patients with only 2 people on there, 1 assistant, 1 physio. So there's way you could get through and do intensive rehab and do 2 half hour sessions per day for every one of those patients	Interivew 3 page 2
in some respects it is different because they may have some different equipment there. They may have a separate gym there…culture there…the philosophy of how they work there. So for instance…it's hard to reflect on the (new facility) at the moment but the old (intermediate care unit), they used to have to go down to the day room for their meals etc, so it was kind of getting people in to that normal routine and function in everyday. So in that respect it might be different but the actual hands-on may not be that much different	Interview 3 page 2
But you're right, it could be a place...or a philosophy of…what do I do in this rehab? And that's what I'm trying to work on at the moment with regard to a service development I'm doing. I think it's changing that culture of rehab on the wards and getting everyone to participate and getting everyone to realise that rehabilitation is their job, including the patients. So what I'm working on is to do a patient information leaflet to say you're now nearing the end of your medical treatment or at the end of your medical treatment and the focus is now on you doing what you need to do are getting towards that rehab part of their stay and em…and then getting the healthcares etc involved. So everything that patient does is then focussed towards function and rehabilitation. So they would no longer give them a wash…so to say they expect the patient to try and wash themselves. They wouldn't bring a commode by the bed, they would get the patient to walk to the toilet and do it for themselves. That's what I want to create	Interview 3 page 2/3

on the ward and it takes that whole emphasis about…oh physio, they're rehab, they're mobility. It's not…it's everybody's job to get involved with that. So every little bit…like I say, with the numbers on the ward there's no way that physio even spending 10 minutes with somebody, walk them to the window and back, that's not really rehab. So if we can get everyone engaged…they go to the toilet 5 times a day or whatever, then there's another 5 walks during the day. If we can encourage them to get out of bed themselves then there's transfer practice. The idea is that...to actually start to educate the health care assistants in to best techniques to do that so they've got a basic understanding of 'if I stand back here, or if I held them at that point'…then the patient could do it themselves.	
I think if you looked at the wider team and you said 'What's rehab?' to somebody other than the physio's, the OTs etc, those therapists involved in rehab…I think they would give a very simplistic idea of what rehab is…oh yeah you'll walk with the physio and then you'll be better	Interview 3 page 3
and it'll just have in the plan you know, their medical stuff and it'll say 'for physio' or they'll have 'rehab' and you just think what, what?	Interview 3 page 7
give this guy a chance in a rehab environment where they have got better facilities and maybe can spend a bit more time with him	Interview 3 page 10
I've had the question where, 'what are we sending them down there for, the physio's aren't really seeing that patient?'	Interview 3 page 12
people see Physio, they think 'Physio – rehab', that's…I think that's everybody in the population in general. It usually starts with the guy running on the football pitch with the sponge, oh that's what physio does…physio rehab people	Interview 3 page 15
some of the ward is meant to be part rehab for people	Interview 4 page 1
I think either building or regaining skills that will give you some sort of function to complete a goal-orientated task. Not necessarily em…being independent, maybe just learning new techniques or different techniques to be able to carry out a certain task	Interview 4 page 1
And in reality, it's not kind of all singing, all dancing you know, getting soldiers to walk again kind of place	Interview 4 page 2
there'll be people on the ward that we're working with and who are improving but because of the bed pressures they'll be sent to rehab	Interview 4 page 2
people judge rehab on mobility because there was the criteria that you must be mobile with 1 person. So…that's what people were looking for	Interview 4 page 5
if it was going to be quite a complex discharge if there was a lot of problems, it seemed they'll be like they need more time so we'll send them to rehab when there wasn't really a rehab need	Interview 4 page 6
the word rehab…they're going to a rehab ward and there's physio's there and they're going to have therapy and you know…don't get me wrong, it is obviously a rehab facility, but I	Interview 4 page 8

think it does…increase family, relative expectations of what's going to happen when they get there	
the way I look at rehabilitation is having time to work with something…somebody…on some meaningful activity. Say it's…washing and dressing for example, if someone can't manage that. It's working with them daily, having daily input with that person, practicing tasks, so that they can…possibly become independent or improve in their independence in that area that we're looking at. But that relies on having the time to do that	Interview 5 page 1
all the other areas of rehab have dwindled away and there isn't the funding for it, there isn't the time to look in to other areas of ADLs that would need a bit more time, that we could have assistance to support patients in those roles. And then, mobility is really the last thing that we're left with perhaps	Interview 5 page 1
Particularly as we're OTs it should be around all areas of life but it just doesn't seem to be that way in hospital, it's whether people can get up and walk or not.	Interview 5 page 2
now that I'm on ward (respiratory), we talk about patients needing further rehab and they are referred to a Care of the Elderly ward. And numerous times I say in MDT on those wards they have the same number of physiotherapists and OTs and other disciplines on that ward that we have on ward **, the respiratory ward. But because our ward is specifically medical for respiratory patients, they need the beds for those patients and then patients would go to a Care of the Elderly ward which we also refer to as rehab wards. And…it's no different…there isn't any increased support there	Interview 5 page 2
because if you say to a patient that you're going to rehab, the family, they really cling on to that and they're expecting some intense rehabilitation	Interview 5 page 3
even if you look at a ward handover it just says 'rehab'…which it just sort of…we all understand it that they need more time with the physio or the OT, that's how it's understood. it could be something that the OT's working with but it would just be termed 'rehab'. And I think…as I've mentioned on a handover if we see that, we just assume it means they're not back to their baseline mobility	Interview 5 page 4
And the impact that (the new emergency hospital) has on something like rehab…is one area it's had such a massive impact on	Interview 5 page 10

Appendix 6 – Faculty Ethical Approval

northumbria
UNIVERSITY NEWCASTLE

Professor Kathleen McCourt, CBE FRCN
Executive Dean

This matter is being dealt with by:

Dr Nick Neave
Director of Ethics
Faculty of Health & Life Sciences
Northumberland Building
Newcastle upon Tyne
NE1 8ST

17th July 2015

Dear Gemma

Faculty of Health and Life Sciences Research Ethics Committee

Submission Code: HLS-PHW141515

Title: Rehabilitation Potential Of Older People Admitted To An Acute Hospital – Exploring The Decision Making Process Of Health Professionals

Following independent peer review of the above proposal, I am pleased to inform you that Faculty approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent Disclosure & Barring Service (DBS) if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available on the ELP. Organisation name: HLS0002: Research Ethics and Governance

You may now also proceed with your application (if applicable) to:

- NHS R&D organisations for approval. Please check with the NHS Trust whether you require a Research Passport, Letter(s) of Access or Honorary contract(s).
- NHS or Social Care Research Ethics Committee (REC). [They will require a copy of this letter plus the ethics panel comments and your response to those comments].

You must not commence your research until you have obtained all necessary external approvals.

The University strongly advises that the supervisor accompany the student when attending an external REC.

All researchers must also notify this office of the following:
- Any significant changes to the study design, by submitting an 'Ethics Amendment Form'
- Any incidents which have an adverse effect on participants, researchers or study outcomes, by submitting an 'Ethical incident Form'
- Any suspension or abandonment of the study

We wish you well in your research endeavours.

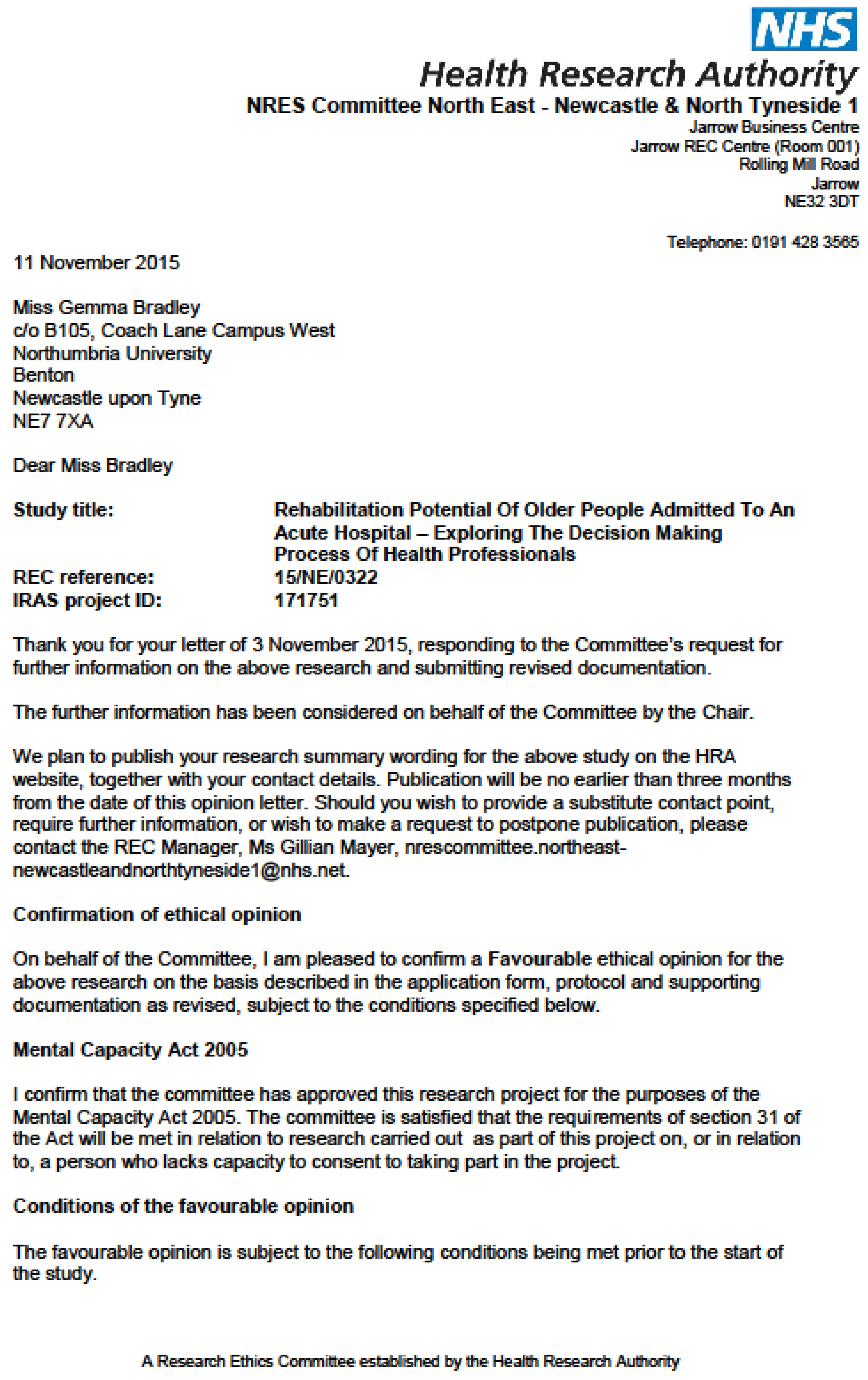
Yours sincerely

Dr Joanna Reynolds
Faculty Ethics Coordinator: Department of Public Health and Wellbeing

Vice-Chancellor and Chief Executive
Professor Andrew Wathey

Northumbria University is the trading name of the University of Northumbria at Newcastle

Appendix 7 – NHS Research Ethics Committee Approval



NHS
Health Research Authority
NRES Committee North East - Newcastle & North Tyneside 1
Jarrow Business Centre
Jarrow REC Centre (Room 001)
Rolling Mill Road
Jarrow
NE32 3DT

Telephone: 0191 428 3565

11 November 2015

Miss Gemma Bradley
c/o B105, Coach Lane Campus West
Northumbria University
Benton
Newcastle upon Tyne
NE7 7XA

Dear Miss Bradley

Study title:	**Rehabilitation Potential Of Older People Admitted To An Acute Hospital – Exploring The Decision Making Process Of Health Professionals**
REC reference:	**15/NE/0322**
IRAS project ID:	**171751**

Thank you for your letter of 3 November 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Ms Gillian Mayer, nrescommittee.northeast-newcastleandnorthtyneside1@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a **Favourable** ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Appendix 8 - Participant Information for all core staff on base ward

Information for Staff on Ward ***

Study Title: Rehabilitation potential of older people admitted to an acute hospital - exploring the decision making process of health professionals

I would like to inform you of a research study being carried out within your place of work. Before the study commences, it is important that you understand why the research is being done and what it would involve for you. This information leaflet provides background information about the study alongside answering some of the common questions that people have about involvement in research.

Please take time to read the following information. Please contact me if there is anything that is not clear, or you would like more information.

This study is part of study towards a post graduate research degree. It has been reviewed and approved by the research ethics committee of the Faculty of Health and Life Sciences at Northumbria University and the Research and Development department of Northumbria Healthcare Trust.

What is the research study about?

This study will explore the decision making of health professionals who are involved in making decisions about rehabilitation potential and subsequent pathways of care and treatment for older people following an unplanned admission to your hospital. Older people often experience longer hospital stays and have more complex needs than other patient groups, and understanding pathways for this patient group, alongside the decisions that influence those pathways, is increasingly important.

The research will predominantly focus on the decision making of Occupational Therapists and Physiotherapists as these professionals have not been the focus of previous research, although there may be times when the researcher will be involved in activities which also involve other members of staff, patients and carers.

Who is the researcher?

The researcher is a qualified Occupational Therapist who now works as a Senior Lecturer at Northumbria University. She is undertaking this research as part of a Post Graduate Research Degree (PhD).

What does the research involve?

The researcher would like to spend time in your clinical area to understand the decisions made for older people following an unplanned admission. In particular the researcher would like to understand what activities happen to support decisions (assessments, handovers, MDT meetings), the involvement of professionals and patients in such decisions and the influences on these decisions at the time they are being made.

Phase 1 of the research will involve periods of workplace observations to enable the researcher to become familiar with the organisation and the environment and to understand activities and processes which happen within this environment to support decision making.

Phase 2 will involve, the researcher, in collaboration with the ward team, identifying particular patients to ‘track’ during their admission and will carry out more focussed individual observations of particular assessments and meetings, and interviews with staff and patients. All of these activities will relate to the episode of care for the identified patients.

How does this involve me?

You are a practitioner who is involved in the care and treatment of older people on the ward where the research is taking place. I have been given permission from your trust and from your service managers to carry out this research and would now like to ask for your consent to observe your routine practices.

What am I being asked to do?

You are being asked to be part of Phase 1 of the research. During this stage, the researcher simply wants to understand the organisation that you work within and gain an overview of what activities happen to support decision making for older people following their unplanned admission to hospital. The researcher would like to be present during activities such as ward rounds or multi-disciplinary meetings. At this stage, the researchers role will be mainly non-participatory (i.e. she will mainly observe in an unobtrusive way) although may ask you some questions to further develop her understanding of processes. The researcher will always introduce herself during such activities, explain what she is focussing on and ask all staff present whether they are comfortable and think it is appropriate for her to be present. Please also be reassured that the researcher has permission from your organisation to be present when confidential information is being discussed about patients, staff, or ward activities.

During Phase 2 of the research, the researcher may also ask for your help in identifying appropriate patients to ‘track’ during their admission. She will fully explain to you the type of patients she would like to include in the research.

What are the benefits of taking part?

On an individual level, it may be that you experience personal benefit in thinking about and discussing the decision making process following an unplanned hospital admission. You could also reflect on the experience of being a participant in a research study and use this as evidence of continuing professional development.

At a professional and organisational level, you will be making an important contribution to the evidence base underpinning the understanding of decision making in relation to rehabilitation and services for older people. The findings of the research could help to inform local service development in this area and contribute to wider developments in relation to these issues.

Are there any disadvantages of taking part?

It may be that you find the process of being observed or discussing your practice uncomfortable. If this is the case, you can ask the researcher to terminate an observation at any time. The researcher will also have contact details of identified people within your organisation who you can talk to if you have found any element of the experience uncomfortable.

Some people worry that the things they say will be identifiable to them. Please be reassured that any information you share will be treated as confidential and will be anonymised within any subsequent reports, projects or publications.

What happens if I don’t want to participate?

You are under no obligation to participate in this study and a decision not to take part will have no adverse consequences for you. If you do not want to participate, the researcher will not observe any activities which involve you.

What would happen if I agree and then I change my mind?

Before each contact with the researcher, she will always check that your consent is still ongoing and you are happy for her to be present. You can also ask to withdraw from the study at any time although any anonymised data that was gathered when you were in agreement could still be used within the study.

What about other people present when you are observing me – will they also need to consent?

During phase 1, the researcher will not be directly observing patient or family interactions. However, notices will be on display to inform patients and visitors (including staff visitors) that there is a research project being carried out within the ward.

If the researcher would like to approach patients, family members or wider staff to become more involved in the research during phase 2, she will approach them with further information and ask for full, written consent.

The researcher may be present when information about other patients or staff is being discussed. The researcher has the relevant permissions from the Research and Development department of your Trust to be present when service user or staff information is discussed.

How will information be collected?

During observational stages, data will be collected through notes taken by the researcher.

What will happen to the information that is collected?

All notes (and subsequent electronic files) will be anonymised and will not contain any personal information. They will be stored securely (either electronically on a secure, password protected server through the university, or hard copies in locked storage areas only accessed by the researcher) until the end of the study and then will be destroyed. I would like to reassure you that any information given by you will only be used for the purpose of this research study alone.

How will whatever I say be anonymised?

Please be assured that all the information shared during an observation or an interview will be anonymised. When the study is written up and disseminated, no names will be identified and participants and episodes of observation will be referred to using numbers/codes (e.g. Observation 1/Participant 1). Nobody will be able to identify any individual in the final write-up or subsequent publications.

How will the research be disseminated?

As this research is part of a research degree, the research will be written up as part of the final thesis for the PhD award. A shorter summary will also be shared with all of the teams involved in the study, service managers and other key members of your Trust, alongside members of staff at the university.

I also hope to publish the study in relevant peer-reviewed journals and present the findings both internally to members of academic staff at Northumbria University and externally, at relevant conferences.

Who do I contact if I want to ask more questions about the study?

Please do not hesitate to contact me directly if you require further information or would like to chat about this study.

My contact details are:

Gemma Bradley

Room H215, Coach Lane Campus East, Northumbria University, Coach Lane,
Benton, Newcastle Upon Tyne. NE7 7XA

Telephone: 0191 215 6289 Email: gemma.bradley@northumbria.ac.uk

Alternatively, you can contact my principal supervisor:

Dr Katherine Baker

Room ***, Coach Lane Campus West, Northumbria University, Coach Lane, Benton,
Newcastle Upon Tye, NE7 7XA

Telephone: 0191 215 6723 Email: Katherine.baker@northumbria.ac.uk

Many thanks for your support

Appendix 9 – Written summary/poster to introduce research to all staff, patients and visitors

Information for all Patients, Carers and Visitors to Ward ***

This summary contains information about a research study which is currently being carried out on this ward. Please take a few moments to read this information

What is the research about?

The research is exploring what happens to older people following an unplanned admission to hospital and is particularly focussing on the decision making of health professionals who are involved in the care and treatment of older people.

Who is the researcher?

The researcher is a registered Occupational Therapist with experience of working with older people in hospitals. She current works as a lecturer at Northumbria University. This means she is independent to the Trust although has full permission to be carrying out the research.

What does this mean for you?

During the course of the research, the researcher is spending time on this unit to understand how decisions are made and will be spending time with different members of staff, and then observing and interviewing staff and patients. At this stage, you are not being asked to do anything although youmay see the researcher during ward activities (for example ward rounds), or spending time with other staff or patients. The researcher will always introduce herself and explain what she is doing. If you do not wish her to be present, please just let her know and please be reassured that this will not affect your care or treatment in any way.

Will I be involved in the research?

At a particular stage in the research, the researcher would like to more directly involve particular staff, patients and carers, because they have particular experiences which are of interest to the project. If this applies to you, the researcher will provide detailed information about what you are being asked to do and will ask for your full informed consent.

How can I ask questions about the research?

If you see the researcher on the ward, please feel free to ask questions directly. If you would like to ask questions but do not know how to contact the researcher, please ask a member of the ward team who can either answer questions directly or pass on questions to the researcher. You can also contact the researcher directly using the details below:

Gemma Bradley

Room H215, Coach Lane Campus East, Northumbria University, Coach Lane,
Benton, Newcastle Upon Tyne. NE7 7XA

Telephone: 0191 215 6289 Email: gemma.bradley@northumbria.ac.uk

This study is part of study towards a post graduate research degree. It has been approved by the research ethics committee of the Faculty of Health and Life Sciences at Northumbria University and the Research and Development department of Northumbria Healthcare Trust.

Appendix 10 - Participant Information for Patients and Carers – At a glance summary

Study Title: Rehabilitation potential of older people admitted to an acute hospital - exploring the decision making process of health professionals

This information sheet summarises key information about a research study that you are being asked to participate in:

- The research aims to understand how decisions are made following the admission of an older person to hospital. Many of these decisions affect where that person goes next, or what services they receive and these decisions are of interest.

- The researcher has full permission from the trust to be on the ward and to talk to you as part of this study.

- You are being asked to participate because your experience is of particular interest to the researcher.

- The researcher would like to be present during some of your contacts with health professionals – she will try to simply observe during these contact but is happy to answer any of your questions.

- She would then like to talk about your experience, ideally before you leave this ward. She will find a private room on the ward to do this and would be happy for a carer or relative to be present with you.

- If you were happy, the researcher would like to audio-record this interview.

- The researcher would also like to be able to view your clinical records to review how your care, and decisions about your care, has been documented. She will not take the records off the ward and will not use any identifiable information about you.

- To give permission for the researcher to do these things, she will ask you to sign a consent form.

- Even if you give your consent, the researcher will always introduce herself to you again so you understand why she is there and what she is doing. If you have changed your mind or do not want her there that day, you just have to let the researcher know.

- The researcher will ensure she anonymises any information and stores this securely and confidentially. There will be nothing in any research reports or publications which identifies you.

- You are under no obligation to take part and if you do not take part, your routine care will not be affected.

Appendix 11 – Extended Participant Information for Patients, Families and Carers

Study Title: Rehabilitation potential of older people admitted to an acute hospital - exploring the decision making process of health professionals

I would like to tell you about a research study that is currently taking place within your ward.

Please take time to read the following information. Please contact me if there is anything that is not clear, or you would like more information.

This study is part of study towards a post graduate research degree. It has been reviewed and approved by the research ethics committee of the Faculty of Health and Life Sciences at Northumbria University and the Research and Development department of Northumbria Healthcare Trust.

What is the research study about?

This research study will explore decisions made following unplanned admissions to hospital for older people. Older people often experience longer hospital stays and have more complex needs than other patient groups, and understanding experiences for this patient group, alongside the decisions that take place, is increasingly important.

The researcher is working alongside departments and wards within this Trust to identify older people, following an unplanned admission, where decisions regarding future improvements, needs and recommended services will be made. For a small number of these patients, within an identified time period, the researcher would like to be present during assessments and interactions with patients and family members, and during professional activities such as handovers and multi-disciplinary meetings. The researcher would then like to interview both health professionals and patients, asking questions about the decisions made and the decision making process.

The health professionals involved will predominantly include Occupational Therapists and Physiotherapists (as research in the past has focussed on other professionals such as doctors). The study would also like to explore your experience as a patient during the decision making process.

This research is currently being undertaken within the ward that you have been admitted to. You may see the researcher involved in different activities and spending time on the ward.

Who is the researcher?

The researcher is a qualified Occupational Therapist who now works as a Senior Lecturer at Northumbria University. She is undertaking this research as part of a Post Graduate Research Degree (PhD).

How does this affect me?

You have been identified as an older person, currently on the ward for an unplanned hospital admission. The researcher would like to focus on your experience and your interactions with health professionals to gain insight in to the decisions that are made regarding what happens next following your time on this ward.

What am I being asked to do?

The researcher would like to ask you to be involved in three main ways:

Observe the assessments and interactions you have with health professionals - the researcher would like to be present when particular members of staff are working with or talking to you. The focus of such observations is to understand how decisions are made within the ward and therefore the researcher will not be gathering any personal information about you, your condition or your situation.

In these situations, the researcher will always identify herself and explain the purpose of what she is doing. Even if you have given your consent at an earlier stage, the researcher will always revisit this consent to make sure you are still happy to be involved.

It is important to reassure you that, irrespective of any involvement, this research will not change the care or treatment that you receive in any way.

Carry out a short interview with you to gain a deeper understanding of your experience – following observations, the researcher would like to carry out a short individual interview with you to gain your perspective on the decisions made about what is likely to happen next after your stay on this ward. Where possible, the researcher will try to do this before you move wards or are discharged home, although as decisions are sometimes made at short notice within hospitals, the researcher may make contact with you after this to carry out the interview.

Depending on the situation, the interview will either take place in a private room on your current ward, in a private room of another ward or unit that you may have moved to, or within your home. You may find it helpful to have a family member or friend present and the researcher will ask you about this before making arrangements.

Give permission for the researcher to access your health records – An understanding of decision making can be developed by reviewing healthcare records as these documents provide a record of things that have been said, people who have been present and decisions that have been made. Again, please be reassured that the researcher will not be using any personal information about you, your condition, or your situation.

What are the benefits of taking part?

On an individual level, the researcher does not want to influence your experience and therefore it is hoped that you will not notice any difference in the service and care that you receive.

If you do decide to be involved you will be contributing to a more detailed understanding of decision making following unplanned admissions to hospital for older people and this may contribute to future service developments. More specifically, you will be helping to represent the patient perspective in this area; a perspective where current knowledge is limited.

Are there any disadvantages of taking part?

It may be that you find the process of being observed or discussing your experience uncomfortable. If this is the case, you can ask the researcher to terminate an observation or an interview at any time. The researcher will also have contact details of identified people within the Trust who you can talk to if you have found any element of the experience uncomfortable.

Some people worry that the things they say will be identifiable to them, especially when talking about the experience they have had with members of the healthcare team, or on a particular ward. Please be reassured that any information you share will be treated as confidential and will be anonymised within any subsequent reports, projects or publications.

What happens if I don’t want the researcher to be present during aspects of my care?

As mentioned above, the researcher will always identify herself and explain the purpose of what she is doing on that day. If you do not feel comfortable with the researcher being present during your assessment or interaction then please just say. The researcher can leave at any point and your normal care, treatment and involvement with services will not be affected in any way.

Can I agree to be involved in some parts of the study and not others?

Ideally, the researcher would like to gather information through all of the methods above and therefore contributing to each stage would be beneficial for the study. However, it may be possible to consent to involvement in some areas and not others. If this is appropriate, the researcher will discuss this with you and the written consent form will clearly identify this. Also, the researcher will check that your consent is still ongoing during any new activity.

What would happen if I agree and then I change my mind?

You can indicate at any point during an observation or interview that you have changed your mind and the researcher will be happy to leave or terminate the interview.

It is important to be aware that the researcher may still use anonymised information in the study up until the point that you withdraw your consent.

Can other people be present?

As with any assessment or intervention with a health professional, it is up to **YOU** who you would like to be present.

What type of information is being collected?

During observations, the researcher will be making notes in relation to what is happening and being discussed. Please be reassured that these notes will not include any personal information relating to you or your health condition but instead will be focussed on the things that you and the health professional are saying and doing to help reach decisions about what happens next in your care.

During the interview, the researcher will ask some structured questions and would like to audio-record your responses. She will then transcribe the recordings to gain a written transcript of your words. A trained transcriber may be asked to transcribe on behalf of the researcher although any files given to this person will not contain identifiable information (e.g. they will be labelled ‘participant 1’ rather than using your name).

If the researcher accesses your clinical records, she will be particularly looking at how assessments and decisions are documented.

Will whatever I say be confidential between myself and the researcher?

Information will be treated confidentially. However, there are some exceptions to this, where the researcher may have a duty of care to inform other staff of information. For example, if you highlighted a concern about a member of staff or another patient, the researcher would have a duty to inform relevant other staff members.

How will whatever I say be anonymised?

Codes and numbers will be used to anonymise notes and transcripts. Consent forms which contain participant codes will be stored separately to any subsequent data. When the study is written up and disseminated, no names will be identified and nobody will be able to identify the individuals involved in the study.

How will information be stored?

All audio files and notes will be anonymised and will be stored securely until the end of the study and then will be destroyed. Paper-based information will be stored in locked areas and electronic information will be stored on a secure, password protected server. I would like to reassure you that any information given by you will only be used for the purpose of this research study alone.

How will the findings of the research be shared with others?

Only the researcher will have access to any identifiable information although she may share anonymised information with her research team and supervisors during the research process.

As this research is part of a research degree, the research will be written up as part of the final thesis for the award. It is also hoped that findings will be published in relevant journals and presented at conferences. A shorter summary will also be shared with any interested participants, and with the teams involved in the study, including service managers. If you do decide to participate, the researcher will ask if you would like to receive follow-up information about the study after it is finished.

Who do I contact if I want to ask more questions about the study?

Please do not hesitate to contact me directly if you require further information or would like to chat about this study.

If the study raised an issue that I wanted to complain about, who could I contact?

Initially, you could contact the researcher, or the research supervisor using the contact details below. If you wanted to speak to someone not directly involved in the research, you could contact the Patient Advice and Liaison Service (PALS) on 0800 032 0202

My contact details are:

Gemma Bradley

Telephone: 0191 215 6289

Email: gemma.bradley@northumbria.ac.uk

Alternatively, you can contact my principal supervisor (a senior and experienced researcher within my organisation who is supervising my research):

Dr Katherine Baker

Telephone: 0191 215 6723

Email: Katherine.baker@northumbria.ac.uk

Many thanks for your support

Appendix 12 – Patient Consent Form

Patient Consent Form

Title of research study: Rehabilitation potential of older people admitted to an acute hospital - exploring the decision making process of health professionals

Name of researcher: Gemma Bradley *Please initial each box*

GENERAL	
1. I confirm that I have read and understood the information sheet dated .... (version................) for the above study.	
2. I have had the opportunity to ask questions and have had any questions answered satisfactorily.	
3. I understand that my participation is voluntary, that I am free to withdraw at any time without giving any reason, but that anonymised information gathered until the point I have withdrawn consent may still be used in the study.	
4. I understand that my name and details will be kept confidential and will not appear in any printed documents.	
OBSERVATION	
5. I agree for the researcher to observe elements of my care and for notes about these observations to be included in the research	
INTERVIEW	
6. I agree to be interviewed as part of the above study.	
7. I am happy for my interview responses to be audio-recorded and am happy for resulting information to be included in the research.	
ACCESS TO RECORDS	
8. I agree that my clinical records relating to this admission can be accessed by the researcher for the purpose of this study.	

Please enter your name and date and sign below:

....

Name of Participant Date Signature

....

Researcher Date Signature

(When completed: 1 copy (original) for researcher file; 1 copy for participant)

Appendix 13 – Health Professional Consent Form

Health Professional Consent Form

Title of research study: Rehabilitation potential of older people admitted to an acute hospital - exploring the decision making process of health professionals

Name of researcher: Gemma Bradley

For Involvement in Phase 1: *Please initial each box*

1. I confirm that I have read and understood the information sheet dated .... (version.................) for the above study.	
2. I have had the opportunity to ask questions and have had any questions answered satisfactorily.	
3. I understand that my participation is voluntary, that I am free to withdraw at any time without giving any reason, but that anonymised information gathered until the point I have withdrawn consent may still be used in the study.	
4. I agree for my practice to be observed as part of the above study and anonymised notes about this practice included in the research.	

For Involvement in Phase 2:

5. I agree for my practice, including my work and discussions with patients, to be observed as part of the above study and anonymised notes about this practice included in the research.	
6. I agree to be interviewed as part of the above study.	
7. I am happy for my interview responses to be audio-recorded and am happy for resulting information to be included in the research.	
8. I understand that my name and details will be kept confidential and will not appear in any printed documents.	

Please enter your name and date and sign below:

....

Name of Participant Date Signature

....

Researcher Date Signature

(When completed: 1 copy (original) for researcher file; 1 copy for participant)

Appendix 14 - Process for seeking advice from a consultee

Obtain name and contact details of next of kin from healthcare team

Telephone or face to face contact with next of kin – introduce researcher role and research project and desire to seek advice about involving their next of kin in the research

↓

Ask the next of kin whether, in their opinion:
- There are other individuals who know the person best and would be better placed to support the individual with this decision
- Whether there is anyone who provides regular care for the person
- Whether the person has granted Lasting Power of Attorney to another person
- Whether there is a Court Appointed Deputy?

Obtain names and contact details for any identified individuals

If different to next of kin, or any individual named above, also ask for contact details of person named by the potential participant as the person who could best support them to make a decision.

↓

Provide written and verbal information to the next of kin and any significant other regarding participating in the research project

↓

Ask the next of kin, and any individuals identified as significant from the above information:
- For advice on whether the person should take part in the research project
- What, in their opinion, the person's wishes would be in relation to involvement in the project if they had capacity

↓

All contact with relatives or other individuals to be documented and at least one person to be identified to complete the consultee form

Form to be completed at least 24 hours following initial contact with consultee

Appendix 15 – Consultee Advice Form

Advice from consultee regarding service user involvement in research

Title of research study: Rehabilitation potential of older people admitted to an acute hospital - exploring the decision making process of health professionals

Name of researcher: Gemma Bradley *Please initial each box*

1. I confirm that I have been consulted about [name of participant]'s participation in this research study.	
2. I have had the opportunity to ask questions and have had any questions answered satisfactorily.	
3. I have been asked for my advice about whether [name of participant] should take part in the project and my response is recorded below:	
4. I have been asked what I think the person's feelings and wishes would be, if they had capacity to decide whether to take part and my response is recorded below:	
5. I understand that I can request that he/she is withdrawn from the study at any time without giving any reason and without his/her care being affected, however it has been explained that anonymised information could still be used within the study.	
6. I understand that his/her name and details will be kept confidential and will not appear in any printed documents.	
7. I understand that the researcher may be present during routine parts of his/her care in an observational role.	
8. I understand that the researcher would like to interview him/her and I agree to be present during this interview or nominate another carer or relative.	
9. I understand that relevant sections of his/her care record may be looked at by the researcher	

Please complete the details below:

Name of Participant	
Name of Consultee	

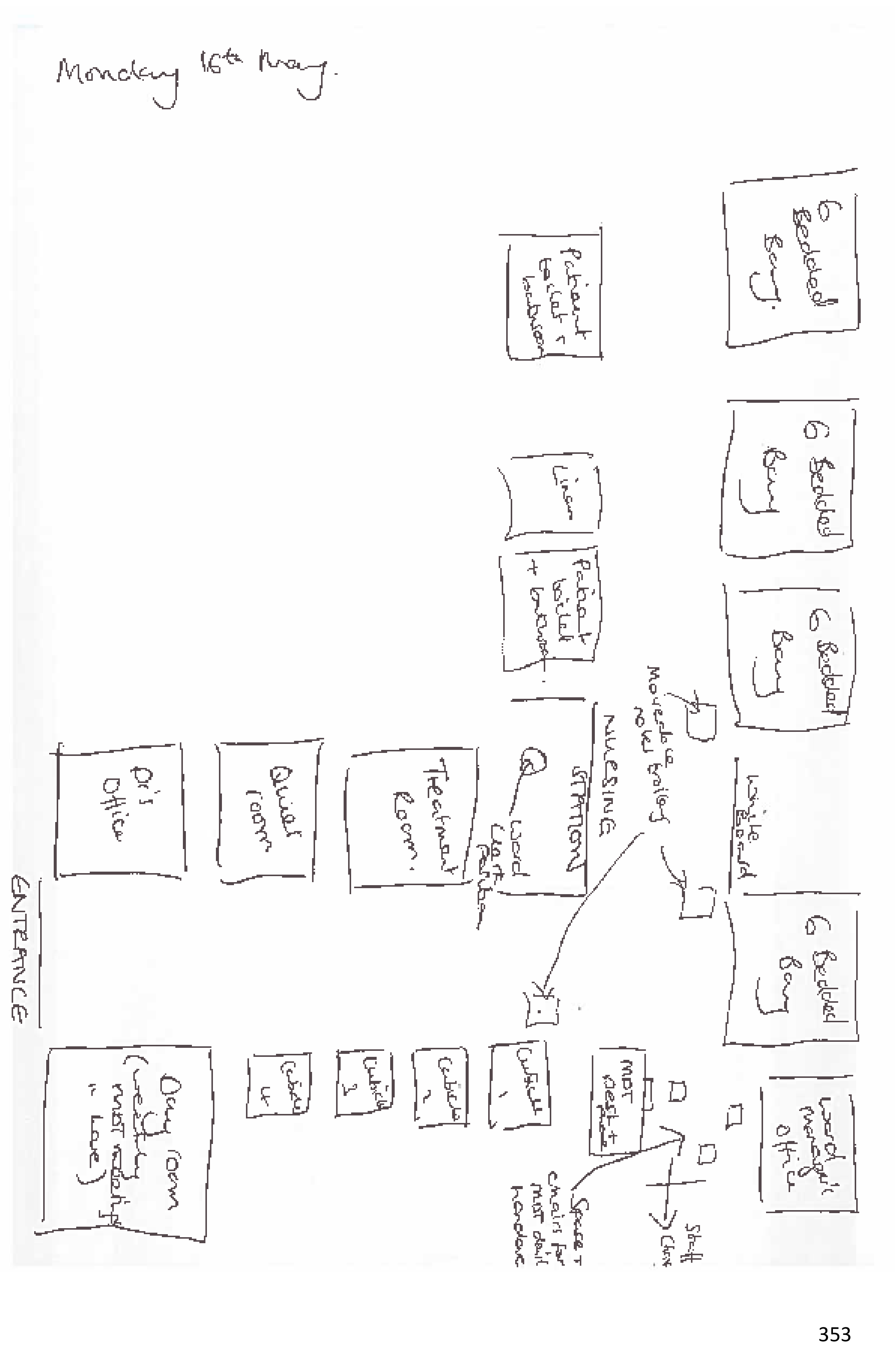
Relationship of Consultee to Paticipant	
Date	
Signature	

For the researcher:

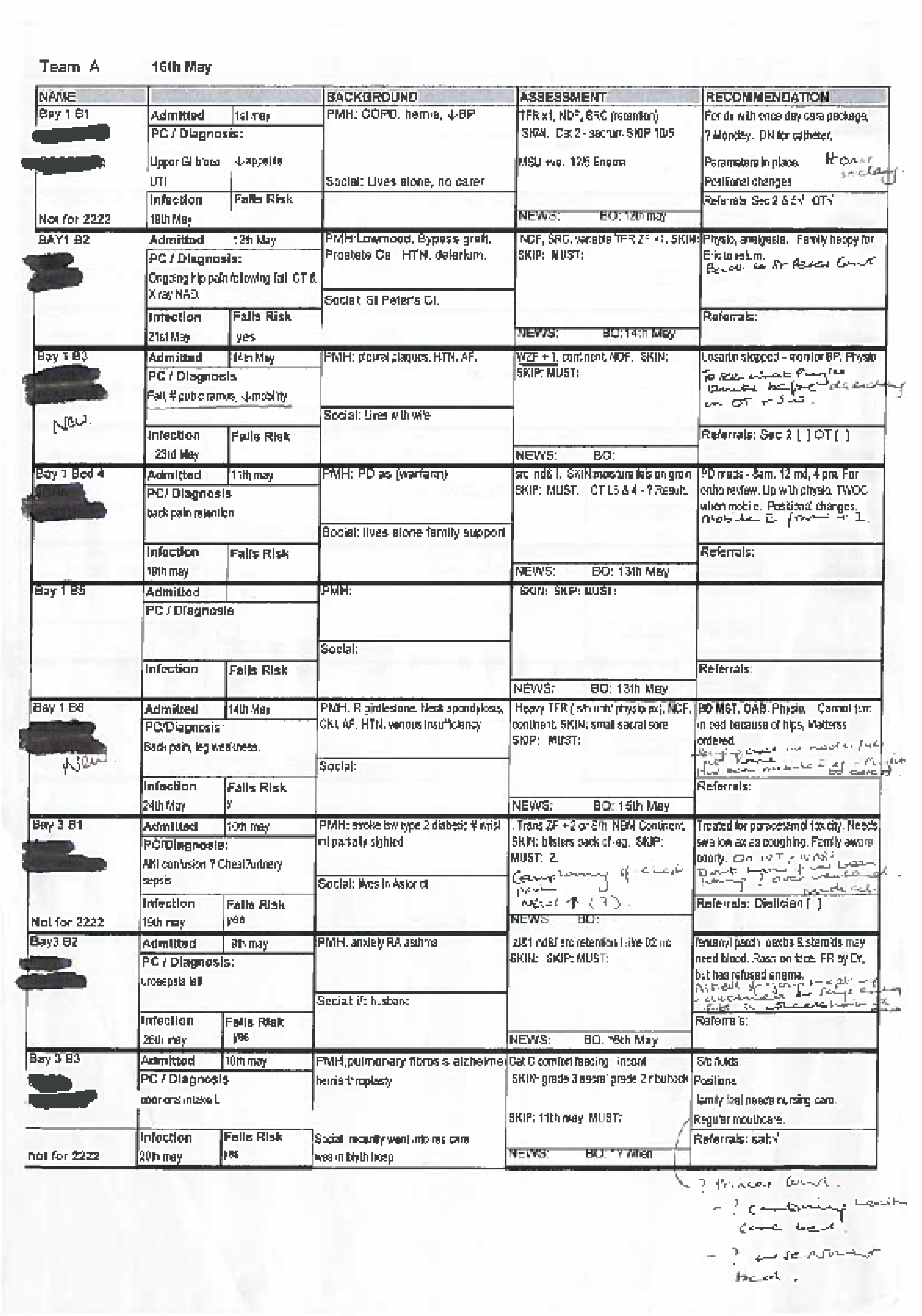
Delete as appropriate Taking in to account the assessment of the person and the advice from the consultee, I have decided to include/not include [name of participant] as a participant in the research	
Name of Researcher	
Date	
Signature	

(When completed: 1 copy (original) for researcher file; 1 copy for participant; 1 copy for consultee)

Appendix 16 – Diagram of base ward (not to scale)



Appendix 17 – Example daily handover sheet



Team A 16th May

NAME		BACKGROUND	ASSESSMENT	RECOMMENDATION
Bay 1 B1 [redacted] Not for 2222	Admitted 1st may PC / Diagnosis: Upper GI bleed ↓appetite UTI Infection 18th May Falls Risk	PMH: COPD. hernia, ↓BP Social: Lives alone, no carer	TFR x1, ND?, SRC (retention) SKIN. Cat 2 - sacrum. SKIP 10/5 MSU +ve. 12/5 Enema NEWS: BO: 12th may	For d/c with once day care package, ? Monday. DN for catheter. Parameters in place. [illegible] Positional changes Referrals: Sec 2 & 5 ✓ OT ✓
BAY1 B2 [redacted]	Admitted 12th May PC / Diagnosis: Ongoing hip pain following fall CT & X ray NAD. Infection 21st May Falls Risk yes	PMH: Lowmood, Bypass graft, Prostate Ca HTN. delerium. Social: St Peter's Ct.	NDF, SRC, variable TFR 2? +1, SKIN: SKIP: MUST: NEWS: BO: 14th May	Physio, analgesia. Family happy for E to return. [illegible] Referrals:
Bay 1 B3 [redacted] New.	Admitted 14th May PC / Diagnosis Fall, # pubic ramus, ↓mobility Infection 23rd May Falls Risk	PMH: pleural plaques. HTN. AF. Social: Lives with wife	WZF + 1. continent. NDF. SKIN: SKIP: MUST: NEWS: BO:	Losartan stopped – monitor BP. Physio [illegible] Referrals: Sec 2 [ ] OT [ ]
Bay 1 Bed 4 [redacted]	Admitted 11th may PC/ Diagnosis back pain retention Infection 19th may Falls Risk	PMH: PD as (warfarin) Social: lives alone family support	sc nd& I. SKIN moisture lesion on groin SKIP: MUST. CT L3 & 4 - ? Result. NEWS: BO: 13th May	PD meds - 8am, 12 md, 4 pm. For ortho review. Up with physio. TWOC when mobile. Positional changes. [illegible] Referrals:
Bay 1 B5	Admitted PC / Diagnosis Infection Falls Risk	PMH: Social:	SKIN: SKIP: MUST: NEWS: BO: 13th May	Referrals:
Bay 1 B6 [redacted] New	Admitted 14th May PC/Diagnosis: Back pain, leg weakness. Infection 24th May Falls Risk y	PMH. R girdlestone. Neck spondylosis, CKI, AF. HTN. venous insufficiency Social:	Heavy TFR ([illegible] physio [illegible]), NCF, continent. SKIN: small sacral sore SKIP: MUST: NEWS: BO: 15th May	BO MGT. OAB. Physio. Cannot turn in bed because of hips. Mattress ordered. [illegible] Referrals:
Bay 3 B1 [redacted] Not for 2222	Admitted 10th may PC/Diagnosis: AKI confusion ? Chest/urinary sepsis Infection 19th may Falls Risk yes	PMH: stroke [illegible] type 2 diabetic [illegible] partially sighted Social: lives in Ashford	. Trans 2F +2 or [illegible] NBM Continent. SKIN: blisters back of leg. SKIP: MUST: 2. Complaining of chest pain [illegible] ↑ (?). NEWS: BO:	Treated for paracetamol toxicity. Needs [illegible] coughing. Family aware poorly. [illegible] Referrals: Dietician [ ]
Bay3 B2 [redacted]	Admitted 8th may PC / Diagnosis: urosepsis fall Infection 25th may Falls Risk yes	PMH. anxiety RA asthma Social: l/c husband	2&1 nd&f src retention [illegible] SKIN: SKIP: MUST: NEWS: BO. 18th May	fentanyl patch, [illegible] & steroids may need blood. Rash on face. FR by Dr, but has refused enema. [illegible] Referrals:
Bay 3 B3 [redacted] not for 2222	Admitted 10th may PC / Diagnosis poor oral intake L Infection 20th may Falls Risk yes	PMH, pulmonary fibrosis alzheimer hemiarthroplasty Social: [illegible] went into res care [illegible]	Cat C comfort feeding. incont SKIN- grade 3 sacral grade 2 r buttock SKIP: 11th may MUST: NEWS: BO: ?? When	S/c fluids. Positions. family feel needs nursing care. Regular mouthcare. Referrals: salt ✓

? Princess [illegible].
– ? continuing health care bed.
– ? [illegible] bed.