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The Lived Experience of a Patient While Receiving Treatment on an Orthopedic Unit After a Hip Fracture: Integrating Research and Theory to Improve Patient Care

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THE LIVED EXPERIENCE OF A PATIENT WHILE RECEIVING TREATMENT ON AN ORTHOPEDIC UNIT AFTER A HIP FRACTURE: INTEGRATING RESEARCH AND THEORY TO IMPROVE PATIENT CARE

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This is to certify that **Margaret A. Kaser** has successfully defended her Graduate Project entitled **"The Lived Experience of a Patient While Receiving Treatment on an Orthopedic Unit After a Hip Fracture: Integrating Research and Theory to Improve Patient Care"** and fulfilled the requirements for the Master of Arts in Nursing degree.

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ABSTRACT

THE LIVED EXPERIENCE OF A PATIENT WHILE RECEIVING TREATMENT ON AN ORTHOPEDIC UNIT AFTER A HIP FRACTURE: INTEGRATING RESEARCH AND THEORY TO IMPROVE PATIENT CARE

MARGARET A. KASER

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_X_ Integrative Thesis

____ Field Project

A hip fracture is a devastating injury for an older person, often resulting in long-term or permanent loss of mobility and independence. Although research has been conducted on various aspects of hip fractures, little research has described the experience of a patient with a hip fracture. This phenomenological study explored the lived experience of a patient receiving treatment on an orthopedic unit after a hip fracture. A purposeful sample of two participants who were hospitalized at Saint Mary's Hospital following a hip fracture were interviewed after surgical repair of the fracture. The interviews were analyzed using Giorgi's descriptive phenomenology. The results of this study will provide a better understanding of the experience of the patient with a hip fracture. Orthopedic nurses and nurse managers will use this information to improve patient care.

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Chapter 1: Introduction

A hip fracture is one of the most devastating injuries an older person can experience. Kain (2000) notes that the functional losses following a hip fracture often lead to emotional and social complications as well. Not only is the fracture a painful injury requiring surgery and a long period of recuperation, it often results in a long-term or permanent loss of mobility and independence (Boockvar et al., 2004; Halm et al., 2003). Although surgery can repair the joint, regaining full mobility and function after the surgery is not as easy. Unfortunately, hip fractures are one of the most frequent injuries resulting in hospitalization on an orthopedic and trauma unit. It is the role of the orthopedic nurse to care for these patients both before and immediately after surgical repair of the fracture. Healing and rehabilitation continue after they leave the hospital. Both the nursing staff and the nurse managers of the orthopedic and trauma units must help patients and their families arrange for this continuing rehabilitation and possibly long-term care after discharge. Moreover, these arrangements must be made quickly because the length of time that most hip fracture patients are in the hospital is restricted by private insurance or Medicare guidelines. Prior to 1990, stays of two weeks or longer in the hospital following hip fractures were not uncommon. Between 1990 and 2003, the average stay declined from 12.8 to 6.5 days (National Center for Health Statistics, 2005). Because of shortened lengths of stays, it is imperative that the discharge planning process be efficient and effective.

Shortened lengths of stay with numerous appointments (e.g., physical therapy), however, have made it difficult for nurses to know and understand the patient. Often it seems that discharge planning consumes more time than direct patient care such as bathing

and toileting. Not surprisingly, many of the hip fracture patients seem overwhelmed by the hip fracture experience and require time to adjust to their new functional status and the need to make plans for post-hospital care. Unfortunately, little is known about this experience from the point of view of the person who has fractured a hip. Understanding the lived experience of the patient with a hip fracture will help to put a human face on the patient, will hopefully result in better care, and facilitate improved discharge planning.

Purpose of the Thesis

The purpose of this thesis is to show how transformational nursing leaders can use information gained through phenomenological research to influence patient care. The research for this study will investigate the lived experience of a patient while receiving treatment on an orthopedic unit after a hip fracture. Phenomenologist use the term *lived experience* to describe those experiences that reveal the immediate awareness or consciousness that someone has about an event or experience that he or she has lived through (Kleiman, 2004, p. 10). This often comes in the form of story telling or story sharing. Nursing leadership theorist Joan Trofino (2000) describes the transformational nursing leader as a storyteller. Sharing the stories of patients who have experienced a hip fracture will lead to a greater understanding of the personal experience of the patient, which will provide much needed information for nursing leaders and nurses.

Hip Fractures in the Elderly Population. The Significance of the Problem

Over 86% of all hip fractures occur in people over the age of 65. Hip fractures account for more days of hospitalization for the elderly than any other injury. It is currently estimated that the prevalence of hip fractures in the elderly is 4.5 per100 per year (Kain, 2000). In Western countries, a woman has about a one in six chance (17.5%)

of sustaining a hip fracture (Huddleston & Whitford, 2001). As the current population of baby boomers ages, the number of people who experience a hip fracture will increase as well. In 1999, the U.S. Census Bureau estimated that the population aged 65 and over will double over the next 40 years (Braithewaite et al., 1999). If the current incidence of hip fracture continues, twice as many hip fractures could occur during that time span.

Boockvar et al. (2004) report that 13.5% of patients die within six months of the fracture. One year later, the mortality rate increases to 24%. Of those who survive past a year, 44% had additional limitations with at least one activity of daily living after the fracture healed. Wolinsky et al. (1997) followed a large, national sample of hip fracture patients for eight years. They found that of those patients who survived the first year, only 54% could walk without help.

The economic cost associated with the fracture is also large for both the patient and society as a whole. Huddleston and Whitford (2001) noted that the costs associated with hip fractures in 1990 were over 8 billion dollars; given the subsequent increase in the elderly population and increases in medical costs, they assume that this figure has increased exponentially and will continue to do so. Hospitals will continue to be under pressure to reduce the cost of hip fracture care. A 2003 investigation by Halm et al. found that physicians and hospitals are under continual pressure from Medicare to shorten the length of time patients with hip fractures remain in the hospital. They noted that the average length of stay has decreased from 20.1 days in 1980 to 6.5 days in 1999. The cost associated with the hospital stay and surgery is only the beginning.

Almost all patients will need some type of rehabilitation services after leaving the hospital and many will need assistance in their homes for an extended period of time, if

not permanently. Whether these costs are paid by government programs (Medicare or Medicaid), private insurance, or personal funds, the economic impact is still great. Since appropriate post-hospital care rehabilitation services can improve functioning, reduce the need for further hospitalizations, and minimize the mortality rate, it is essential that effective discharge planning be a major focus of the staff working in an orthopedic trauma unit. At the same time, this planning must be completed in a very limited time. Nursing leaders on an orthopedic floor are under continual pressure to make sure that the length of stay of patients with hip fractures is within the limits imposed by Medicare and Medicaid. Failure to meet these limits results in a significant loss of reimbursement for the hospital. Balancing the needs of the patient with the financial constraints of reimbursement policies is a constant concern for nursing leaders.

Specific Aim of Research Conducted for this Thesis

The specific purpose of this phenomenological study is to describe the experiences of a patient with a hip fracture while receiving treatment on an orthopedic unit. This phenomenon of interest, the lived experience of a patient while receiving treatment on an orthopedic unit after a hip fracture, has not been explored and analyzed in the United States. Although quantitative research has been conducted on various aspects of hip fractures, very little qualitative research has described the experience of a patient with a hip fracture while receiving treatment in the hospital. The following research question will be addressed in the study: What is the lived experience of a patient while receiving treatment on an orthopedic unit after a hip fracture?

The answer to this question will be used to inform hospital orthopedic and trauma nursing practice and hospital nursing practice in general. Specifically, the nursing leader

will use the research to improve the nursing care and the discharge planning process for the patient with a hip fracture while in the hospital. The nursing leader will also use the knowledge gained in this research to help the nursing staff see beyond the hip fracture and gain an understanding of the person who has experienced this life-altering event. Hopefully, an improvement in the care and discharge of patients with hip fractures will also lead to hospital stays that are within the Medicare proscribed limits.

Theoretical/Conceptual Framework of Research

Descriptive phenomenology will be used to examine the lived experience of patients with hip fractures during their hospital stay. This research will answer the research question: What is the lived experience of a patient while receiving treatment on an orthopedic unit after a hip fracture? Phenomenology is a qualitative research method that offers a means to study experiences and phenomena that are of interest to the nursing discipline. These studies are often difficult to measure and do not lend themselves to quantitative research methods. Like other qualitative research methods, phenomenology provides rich knowledge about experiences and provides meaning for those experiences. This makes phenomenology the ideal method to answer the research question in this study.

Caring for Patients with Hip Fractures: Challenges for Nurse Leaders

Providing appropriate care for patients with hip fractures is not only a challenge for the nursing staff, but also a major concern for the nurse manager. As a transformational leader, the nurse manager's primary concern is the patient. Yet the economic costs cannot be forgotten. Grossman and Valiga (2000) describe a transformational leader as one who can effectively balance the needs of the patient with

the limited resources that are available in the health care setting. This is especially true with hip fracture patients. A nurse manager must balance the human needs of patients with the economic constraints of the hospital and the health care system as well. As a transformational leader, he or she cannot allow the discharge of a patient unless appropriate discharge plans are in place. At the same time, if too many patients remain in the hospital longer than Medicare guidelines allow, the unit and hospital will have difficulties recouping the loss when reimbursement ends. One way to avoid this dilemma is to provide the most effective hospital care and discharge planning possible.

Theoretical Framework: Transformational Nursing Leadership

The healthcare industry faces many challenges in the United States today. On the one hand, healthcare is in the middle of one of the most exciting times in medical history. New discoveries in both science and technology have resulted in revolutionary advances in the ability to diagnose and treat conditions with a skill and success that has not been possible in the past. But at the same time, healthcare providers face financial and organizational challenges that are far greater than they have ever been. Naturally, informed consumers demand the newest and latest treatments. Public and private policy makers, lamenting the availability of affordable healthcare for everyone, are asking for increased access to medical care for all, even those unable to pay. In spite of the demand for more and better services, both government and private insurers are pressing healthcare providers to do all of this with less money. As a result, healthcare leaders are working to find more efficient, effective ways to provide world class care to all. The rapidly changing environment in which healthcare is delivered is forcing leadership to look for new ways of leading.

The nursing profession is very much a part of the challenges healthcare faces. As the organizational structure of healthcare facilities and delivery has changed, the role of the nurse has expanded as well. Nurses often find themselves doing more in their roles than bedside care; activities such as patient education and advocacy, case management, and discharge planning now consume as much of their time as physical care. Usually, they are asked to do all this within the limited time of shorter hospital stays mandated by insurance. Nurses have always been motivated to act in the best interest of the patient. However, in the current environment, nurse managers and leaders often find themselves in the uncomfortable position of having to balance the needs of the patient with the limited resources that are available.

Because of these challenges, many have called for both a new vision and a new style of leadership for the nursing profession. Over the past two decades, nursing leadership has looked for new ways to accomplish the centuries old mission of nursing, which is to care for the sick and the injured. By the late eighties, many nurse leaders were calling for a leadership more suited to the expanded role of the nurse and the changes in the healthcare environment. Transformational leadership is often given as an appropriate choice for nursing leadership.

Transformational Leadership and Nursing Theory

Jean Watson, a nursing theorist who developed the Theory of Human Caring, is also a proponent of transformational leadership. In a 2000 article in the *Nursing Administration Quarterly,* Watson links the Theory of Human Caring to transformational leadership (which she calls transformative leadership). She identifies the transformed leader as "one who leads from caring, yet follows one's own journey" (p. 4). She

identifies a "four-fold path" that she believes "reminds us about the purpose of our work and how our life can speak through compassionate administrative service"(p. 1). One of the essential characteristics of transformative leadership that Watson names is especially applicable. She explains that a leader must "lead from spirit-filled mindfulness and awareness; to lead by listening to others; to listen to the spirit of what is being said, as much as to what is said" (p. 5). This statement describes an important essence of transformational leadership for nursing. Watson's theory is frequently the basis of research. When Smith (2004) reviewed nursing literature from 1988 to 2003, she found forty studies based on Watson's work. Although none of these dealt specifically with transformational leadership, her theory seems particularly applicable to a phenomenological inquiry in which the investigator is concerned with the spirit of what is being said.

Watson's theory supports transformational leadership. However, her primary concern is caring, which she considers "the heart of nursing and the ethical and philosophical foundation for our acts" (1994, p.3). She calls caring the *Core of Nursing* and distinguishes this humanistic core from what she calls the *Trim,* which includes "the practice setting, the procedures, the functional tasks, the specialized clinical focus of disease, technology" (1997, p. 50). Watson recognizes that much of the work of nursing leaders is part of the Trim; she also recognizes that this work is essential. However, this work cannot replace caring. This distinction is important in any discussion of nursing leadership. It speaks to the constant struggle to find balance. In spite of the constant pressures of the current health care environment, caring remains the primary concern of all nurses and nursing leaders.

Chapter 2: Review of Literature

Hip Fractures and Nursing Care: Review of Medical Literature

Hip fractures in the elderly and the long-term outcomes of patients with hip fractures are a frequent topic of medical research. A key word search of the Cumulative Index to Nursing & Allied Health Literature (CINAHL) databases for studies investigating nursing care for hip fracture patients was conducted using the terms 'hip fracture' and 'research.' This search netted 1,181 articles. However, only five were reports of qualitative research studies, and only four of these discussed the actual experience of hip fracture patients or their families.

Archibald (2003) conducted a phenomenological study of hip fracture patients in the United Kingdom. The purpose of the study was to improve nursing practice by developing an understanding of the experiences of patients with fractured hips. Unstructured, taped interviews were conducted at least one month after hospital discharge with five older patients who had spent time in rehabilitation following hip fractures. The data collected dealt with four major aspects of the experience: the injury itself, the pain involved in the treatment and rehabilitation, the recovery process, and the resulting level of disability. He found that both pain management and planning for discharge provided opportunities for nursing care development. Archibald noted that the length of time between the hospital stay and the interview had created memory problems since most of the participants found it difficult to remember how they had felt during the hospital stay.

Bergh, Jakobsson, Sjostrom, and Steen (2005) conducted a phenomenological study in Sweden to determine how older patients described their experience of pain after hip surgery. They interviewed 60 patients on the second day after they had undergone

surgery for a hip fracture or a hip replacement. They found that patients used everyday language to describe their pain. Learning to be aware of the nuances of these descriptions has proven useful to nurses in providing effective pain management.

Pownall (2004) used what she called a patient narrative enquiry to find ways to improve orthopedic nursing care of patients with fractured hips. She interviewed one patient in a hospital in the United Kingdom. The interview took place immediately before the person was discharged to a rehabilitation facility, which was connected to the hospital. Pownall found that more explanations and communication from the nursing staff would have alleviated much of the anxiety and confusion that the patient experienced. This study provided good insight into the experience of one patient. Future research is needed on the lived experience of other patients with hip fractures.

Lin and Lu (2004) conducted a phenomenological study of relatives who cared for a hip fracture patient after hospital discharge in Taiwan. They distributed questionnaires to 98 older people with hip fractures and their caregivers in Taiwan one week and again one month after they were discharged from the hospital. The study showed that all caregivers of persons with hip fractures experienced stress and fatigue; the role was especially difficult for those who had no outside help or support. This study was quite extensive and provided insight into the experience of the caregiver, not the patient. It is important to note that none of these phenomenological studies were conducted in the United States.

Although no other studies explored the lived experience of a patient with a hip fracture, several articles describe issues with nursing care and/or discharge planning for patients with hip fractures. Kain (2000) reports on a team approach to the nursing care of

hip fracture patients, using a holistic care model. This model, which addressed developmental, physiological, psychological, and spiritual factors in patient rehabilitation, resulted in improved patient outcomes. The average patient who received holistic care was in the hospital for three or four days compared to the control group average of five days. Kain provides a good overview of the many problems involved in the care of a hip fracture patient, from postoperative care issues that can arise during the hospital stay to the types of rehabilitation that are needed. She also discusses the emotional, social, and psychological problems that play a role in recovery. Discharge planning was done in this study; although the team involved with the patient was multi-disciplinary, Kain notes that the nurses had the primary responsibility for the discharge planning.

Leininger and Cohen (1998) also describe a multi-disciplinary team approach to hip fracture care in a report on a program at Allegheny University Hospitals in Pennsylvania. They based their team approach on a preoperative assessment tool that was used with all elderly hip fracture patients. This tool allowed them to find the red flags that the staff needed to look out for during the hospital stay and to consider during discharge planning. The use of this tool resulted in better patient outcomes, allowing 61% of the patients on the floor to return home. It also made the discharge planning process more efficient as those patients who were apt to need intermediate care before returning home were identified early in the hospital stay.

Providing effective treatment during the short period in which the patient is hospitalized is an especially important focus now that hospital stays for hip fracture patients are so short. It is interesting that nursing studies done in the eighties and early

nineties did not mention rehabilitation or discharge planning; in that time period, patients received a large part of their rehabilitation in the hospital before returning home. Barangan (1990) and Gill et al. (1994) were both interested in the factors that affected the ability of hip fracture patients to return to their homes and live independently. Barangan identified nursing interventions that could promote recovery from the fracture. Gill evaluated the impact that continuing education for nurses had on the care of patients with hip fractures. Both identified good nursing care as a significant contributor to positive outcomes for patients. However, it is important to note that both studies were done when three-week hospital stays for hip fractures were common.

Several reports discussed the problems that shorter hospital stays cause for hip fracture patients, noting that these stays make discharge planning more important than ever. Halm et al. (2003) investigated the outcomes of hip fracture patients with other medical problems. They found that physicians and hospitals are under pressure from Medicare to shorten the length of time a patient with a hip fracture remains in the hospital. They noted that the decreased length of stay often results in patients being discharged before they are medically stable. They found that the patients who were medically unstable at discharge had a higher rate of death or a decrease in the ability to function after the fracture healed. The authors concluded that physicians needed to be cautious about discharging patients with other medical problems, even if it means ignoring the discharge guidelines established by Medicare.

Levi (1997) investigated a group of older women with hip fractures, comparing their functional outcomes with their post-hospital setting. She found that those who were discharged to a nursing home generally had poorer outcomes than those who either

returned home or went to rehabilitation facilities. She finds this disturbing since more patients with hip fractures are discharged to nursing homes as a result of the shorter hospital stays.

Aharanoff, Barsky, Hiebert, Zuckerman, and Koval (2004) reviewed the hospital discharge records of hip fracture patients in New York between 1986 and 1996. They found that the number of patients discharged from the hospital to nursing homes increased from 25% in 1986 to 53% in 1996. This increase, which was independent of all other factors, was attributed to a reduction in length of hospital stays. However, they also found that patients who received their rehabilitation in a nursing care facility did not fare as well as those who had spent more time in the hospital.

Other research articles support the importance of thoughtful discharge planning. Boockvar et al. (2004) studied the number of relocations, or changes in residence that hip fracture patients in New York State experienced during the six months after a fracture, concluding that frequent relocations led to poorer outcomes. They recommended better discharge planning. Huang and Liang (2005) examined the effectiveness of discharge planning in patients treated for hip fractures in a Taiwan hospital. They found that good discharge planning decreased the rate of readmission to the hospital and improved both the physical outcomes and the quality of life of the hip fracture patients. An audit of hip fractures in seven hospitals in Great Britain identified careful discharge planning as instrumental for improved patient outcomes (Freeman et al., 2002). In another study, Shyu et al. (2005) evaluated the effectiveness of an interdisciplinary intervention program for elderly patients with hip fractures and concluded that those programs that emphasized discharge planning resulted in better long-term outcomes.

These studies provide information about nursing care for patients with hip fractures. However, none of them provided information about the phenomenon of interest, the lived experience of a patient while receiving treatment on an orthopedic unit after a hip fracture.

Transformational Leadership: Review of Literature

James MacGregor Burns (1978) is credited with the first description of the theory of transformational leadership. As Burns studied political and historical leaders, he explored the concept that leaders were those who possessed power. However, he came to realize that while leadership was one aspect of power, it also represented a "separate and vital process in itself" (p.18). The defining principle for leadership, Burns decided, was *purpose*. He looked at what he considered a basic type of leadership that occurs when leaders appeal to the self-interest of their followers and convince them to do something by promising a reward of some sort for doing it. He called this transactional leadership. But while some perceive leadership as this simple process in which leaders cause followers to do what the leaders want, he saw another factor. He saw a type of leadership that consisted of "leaders inducing followers to act for certain goals that represent the values and the motivations—the wants and needs, the aspirations and expectations—*of both leaders and followers"* (p. 19). This is a higher form of leadership that Burns names *transforming* leadership.

To Burns, *transform* is the important word in the definition. He does not believe it should be confused with *change*, which he believes means to substitute one thing for another. "Transformation," he explained, goes beyond change and refers to a "basic alteration in entire systems—revolutions that replace one structure of power with

another" (2003, p. 24). It is this quality that a leader needs; simply making changes is not enough. Transforming leaders must be able to unite and lead their followers through major alterations in the fabric of their existence.

When he wrote his first book on leadership, Burns was concerned primarily with political leadership. In 1985, Bernard Bass expanded Burns's concept in the book *Leadership and Performance Beyond Expectations,* and demonstrated how the theory of transformational leadership could be applied to a wide range of organizations. He also looked at the distinction that Burns makes between transactional and transformational leadership. Unlike Burns, he did not necessarily see these as two different types of leadership. Rather, he believes that they often coexist within the same leader. Bass recently explained that as he studied Burns's theory, he came to realize that "transformational leadership is in some ways an expansion of transactional leadership" (2006, p. 4). As he has studied the leadership research that has been done, he realized that most leaders engaged in both types of leadership, and it did not make sense to think of them as an either/or proposition. He finds that many of the routine tasks of a leader are directive and therefore qualify as transactional. However, this same leader may move their leadership to the next level with other parts of the leadership role and also be a transformational leader.

In 1985, Bass determined that transformational leadership consisted of three distinct components, which he identified as charisma, intellectual stimulation, and individualized consideration. He notes in his most recent book that these components have evolved somewhat and others have been added as "refinements have been made in both the conceptualization and measurement of transformational leadership" (2006, p. 5).

Nevertheless, he continues to identity transformational leadership as charismatic in concept, meaning that followers identify with the leader and want to be like him or her. Second, he believes that transformational leadership is intellectually stimulating as the leader "inspires followers with challenge and persuasion, providing meaning" (p. 5) for both leader and follower. The final component is individual consideration; the leader provides each follower with the support and mentoring that he or she needs to be successful. Bass believes that none of these components are rare. Charisma, for example, can be found in many people in varying degrees. He believes that it should be encouraged and developed. In his later writing, he often refers to charisma, as "idealized influence and inspirational leadership" (p. 24). He believes that these characteristics are seen in a leader who "envisions a desirable future, articulates how it can be reached, sets an example to be followed, sets high standards of performance, and shows determination and confidence" (1999, p. 11).

As these qualities are identified in successful leaders, transformational leadership has become a widely accepted leadership model. It has been implemented successfully in a wide range of organizations. Although healthcare organizations are not mentioned by either Burns or Bass, by the early nineties, many healthcare leaders were exploring transformational leadership as an effective approach in healthcare.

Transformational leadership for nursing

There is little question that both the profession of nursing and healthcare organizations have changed dramatically. A new vision and new types of leadership are needed to face the many challenges that lie ahead. However, neither leadership nor vision changes have happened easily. In 1987, nursing policy-maker Porter-O'Grady called for

a new way of organizing nursing leadership. He noted that nurses had been relegated to "dependent employee roles" (p. 286) for too long. He does not mention transformational leadership at this point, but does call for shared governance in organizational changes, allowing nurses to join management at the table. This seems minor, but represented a major change in viewpoint at that time. Traditionally, nursing management has emphasized hierarchical structures and autocratic control. Until recently, nurses took orders from many different supervisors, whether doctors, administrators, or head nurses. In the traditional nursing department, the staff nurses who were responsible for direct patient care had virtually no input into the decision making process. While this has changed to some extent, many vestiges of the old hierarchy remain. Many nursing leaders have called for changes in this hierarchy, but change has been slow.

Barker (1992) addressed the lack of nurse representation in decision making. She explained that during the preceding two decades, nurses had become interested in the concept of power. As nurses lived through many changes in the health care environment, they became interested in how they could acquire and use power. She explains that this concern with power was "the result of nurses, as a group, feeling 'powerless'" (p. 48). Barker believes that transformational leadership is the answer to this search for power. She explains that while all leadership is about power, transformational leadership is about empowerment. The power of the transformational leader is found only when it is used in the best interest of the followers and shared with them.

In 1993, Davidhizar also saw transformational leadership as the solution to many of the problems that the nursing profession faced. Writing about charismatic leaders in the *Journal of Advanced Nursing*, she notes that when "techniques of transformational

leadership appear in health care organizations, the traditional emphasis on hierarchical structures, logical decision making, and rationality become less prominent" (p. 675). She believes that the leader who uses charisma and transformational leadership is able to communicate a vision to followers that would help lead nurses into a new era of healthcare.

Trofino was one of the first nursing leaders to call for transformational leadership. She has published many articles about leadership in nursing journals. She also recognized that nursing needed not only more power, but also a new vision. She noted that in spite of their major role in health care, nurses "have remained largely a silent majority . . . and still do not wield the political power and authority equal to their numbers" (1993, p. 180). She believed that transformational leadership could change this; she saw transformational leaders as those who "have the ability to clearly articulate a vision of the future. The picture they describe and the values they emulate are so exciting and meaningful that they cause strong commitment by others" (p. 179). She felt that the transformational leader could lead the profession into a new era.

Change has come slowly in many areas of nursing, however. Although Trofino continued to write about transformational leadership throughout the nineties, it was not always implemented as a workable theory for nursing. In 2000, Trofino wrote that future nursing leadership must "be willing to say farewell to command and control . . . and be willing to share power" (p. 232), something which has not happened as yet. She called on nurses to "influence the use of transformational strategies in health-care organizations" (p. 232). She also explains how these strategies can be used to effectively transform healthcare organizations.

Benefits of Transformational Nursing Leadership

Those nursing organizations who have implemented transformational leadership have seen a variety of benefits. In general, those describing the advantages have focused on three categories: staff satisfaction and retention; patient satisfaction; better financial outcomes.

Wolf, Hayden, and Bradle (2004) describe a system-wide decision to use a transformational model for nursing care delivery after the merger of 19 different hospitals working together as part of the University of Pittsburgh Medical Center. The researchers noted general benefits in each of the three categories. They provided hard data showing that patients were receiving faster and better care. As nurses took over much of the staffing control, the staffing levels were more evenly distributed resulting in better workloads and increased satisfaction among nurses. The staff changes also resulted in significant savings in money as fewer units ended up with excess nurses on some shifts.

Staff satisfaction is the most frequently named benefit of transformational leadership. Kleinman (2004) reported the results of a study of nurse manager leadership styles in a large community hospital in the Northeast. Using the Multifactor Leadership Questionnaire (MLQ) for both staff and managers, she demonstrated that those managers who were identified as primarily transformational were more apt to retain staff nurses than were those managers who exhibited a mostly transactional management style. In fact, Kleinman found that staff turnover was frequent with transactional leaders. In another study, Trott and Windsor (1999) found that staff nurses felt that transformational leaders supported and believed in them. This in turn led to greater staff satisfaction. Dunham-Taylor (2000) conducted a study of nursing executives and found that both staff

satisfaction and nurse effectiveness were high with transformational leaders. Both staff and patient satisfaction decreased with transactional leaders. Al-Mailam (2005) studied the effect of nursing care on patient satisfaction, and discovered that the overall patient satisfaction is directly linked to the quality of nursing care. Moreover, he found that transformational leadership resulted in greater nurse satisfaction, which led to higher quality care. He surmised that nurses who were satisfied with their jobs were able to provide better care. Zwingman-Bagley (1999) reported that transformational leadership led to cost savings when nurses were empowered to help with difficult financial decisions.

It is almost impossible to open a nursing journal today without finding an article promoting transformational leadership as an answer to many of the problems that face healthcare and nursing today. Many healthcare providers and nursing organizations describe their experiences with implementing a transformational leadership style. Various measurements of its success have been provided. No one openly questions its effectiveness. Yet, outside of official circles, some nursing leaders question the appropriateness of transformational leadership in nursing.

The actual essence of transformational leadership—the original three components that Bass set forth—do not seem to be the problem. Few question the value of charismatic leaders who support staff and lead them with a vision. The biggest complaints seem to revolve around the time that should be involved in shared decision making. Trott and Windsor (1999) note that in the past nurse managers were responsible for the resources of their departments; they could make decisions quickly and easily. They are still responsible for their resources today and are under even greater pressure to improve the

care outcomes of their areas. Now, however, they have more steps to go through and are expected to "actively solicit feedback from staff regarding key aspects of leadership effectiveness" (p. 127). Trott and Windsor also found that a transactional leader is more effective than a transformational leader in crisis situations or any situation that needs a quick decision and short-term solution. Since those situations occur frequently in most nursing areas, it is easy to see the advantages of the fast-acting transactional leader.

However, Bass (1985) found that most leaders used both transactional and transformational leadership, depending on the situation. When dealing with many decisions required on a nursing unit, both critical and routine, a nursing leader will often need to use a transactional or directive style. But the overall leadership will remain transformational with the nurse leader creating a unit in which a shared vision is the basis for all major decisions. Many of the complaints about the time that transformational leadership requires may be only a reaction to change. For those nurses who were comfortable in the old hierarchy, change is difficult to accept. When the multiple changes in the healthcare environment are combined with a change in the organizational structure, there is apt to be resistance. It is not uncommon to hear older nurses complain that the old ways worked just fine.

Nurses work in a wide variety of situations, and different management skills may well be needed for each. Haase-Herrick (2005) notes that where nurses practice "shapes the finer specifics of their management skills and competencies. Their leadership competencies, however, must transcend the specific locus of their practice" (p. 115). Nurses need to concentrate on a "long-term focus" and become part of "the transformational process of engaging others in solutions and actions" (p. 116). Only with

these transformational characteristics will nurse leaders be able to deal with the challenges that healthcare and nursing face.

The art of balancing both styles of leadership is something that nurse managers of the future will need to learn. For this reason, transformational leadership is an appropriate choice for nursing. Many nursing leaders have been strong advocates for transformational leadership, but the proponent who best describes this leadership is Trofino (1993). She articulates very clearly who the transformational nursing leader is, and clarifies what it is that separates this leader from others. She paints a picture of the transformational leader as a storyteller who can describe a future so clearly that others want to join her. This image resonates because it is so much a part of the fabric of holistic nursing. Storytelling is an integral part of nursing. The idea of a nursing leader as a storyteller who leads by presenting a vision of the future seems appropriate.

At the same time, listening to the stories of those she leads will allow a leader to care for each staff member as an individual. Trofino emphasizes the importance of the caring dimension for the transformational leader, describing the necessity of leaders caring for those they lead. Like storytelling, caring is integral to nursing. Trofino explains that transformational leadership will do more than empower nurses; it will also make them feel cared for, something she considers very important since she has found that "before nurses can care for others with commitment and excellence, they must first feel cared about by both co-workers and employers" (1993, p. 187). The transformational nursing leader who cares for her staff and can engage them with a vision (or story) will transform nursing practice.

Chapter 3: Methodology

Research Method

Descriptive phenomenology is the research method chosen to frame the research question for this study. This is the study of an observed event or phenomenon (Speziale, 2003). It has its origins with Husserl, a German philosopher who is credited with using phenomenology to uncover meanings in observed events. Kleiman (2004) writes that Husserl proposed a "method of inquiry that was not concerned with origins or a deductive exploration . . . but rather a method for investigating and describing the presence of any phenomenon given to consciousness, precisely as it is given or experienced" (p. 8). From these beginnings, phenomenology has evolved into a qualitative research method with many variations.

Although various types of phenomenology have been identified, the majority can fit into two categories: descriptive and interpretive. Descriptive phenomenology, the method proposed for this study, is often referred to as Husserlian phenomenology as it is based on Husserl's original philosophy. Kleiman (2004) writes that "in descriptive phenomenology, a researcher is interested in discovering meanings of phenomena from lived experiences rather than from universal principals" (p. 9). Many other theorists have written about phenomenology, all proposing their own variations. However, they all share a similar process. All rely on identifying and interviewing people who have lived or are living the experience. This process allows the researcher to obtain first-hand perceptions of the experience. The researcher then takes these descriptions and divides them into meaningful units. Finally, the researcher is able to describe the essential meaning of the experience.

This study used the descriptive phenomenology techniques as proposed by Giorgi (2005) for use in human sciences. Giorgi, a psychologist who specializes in the area of qualitative psychological research practices, has written extensively about applying phenomenological methods to psychology. He believes that only by using a qualitative method can a researcher obtain accurate knowledge about the human experience. He has also published several articles about the applicability of phenomenology to nursing research, which he calls a human science like psychology.

Phenomenologists have their own vocabulary. The following terms are used frequently by Giorgi and other descriptive phenomenologists. First of all, *essences* are those elements that are essential to the true meaning of something. Giorgi (1997) explains essences as the "most invariant meaning for a context" (p. 5). He also notes that essence allows the researcher to arrive at a "fundamental meaning without which a phenomenon could not present itself as it is" (p. 5). A second term is *intuiting,* which in phenomenology means the accurate interpretation of the phenomenological description. A third widely used term is *lived experience*, which refers to those experiences that reveal the immediate awareness or consciousness that someone has about an event or experience that he or she has lived through (Kleiman, 2004, p. 10). Understanding the concept of the lived experience is essential to understanding the phenomenological method. Phenomenologists believe that by investigating the subjective phenomena of lived experiences, they will find essential truths about reality. They also believe in the truthfulness of the lived experiences described by those who have experienced them (Giorgi, 2000).

Phenomenological reduction is another term used by phenomenologists. According to Giorgi (1999), this is a device that Husserl invented to add preciseness to research findings. It requires researchers to return to the original meaning of the phenomenon under investigation instead of their interpretation of the experience given by the person experiencing the phenomenon. This requires that researchers remove their own prejudices, preconceptions, and past knowledge about the phenomenon so that they can "be fully present to it as it is in the concrete situation in which one is encountering it" (Giorgi, 1997, p. 3). The first part of this process, called *bracketing,* is the process in which researchers remove their own perceptions so that they can get an unbiased picture of the phenomenon. Giorgi explains that the researcher has to "withhold past knowledge about the phenomenon . . . in order to be fully present to the concrete instance of the phenomenon as presented by the subject's description" (1997, p. 5). The process of bracketing begins prior to interviewing participants; the researcher contemplates and often journals or writes about his or her beliefs and perceptions of the phenomenon being studied. Once these beliefs have been identified, the researcher then can set them aside during the interviews and the interpretation of the interviews.

Giorgi (1997) calls his method the Human Scientific Phenomenological Method. He believes that it is essential to distinguish Husserlian phenomenology, which is a philosophy, from scientific phenomenology. Giorgi's phenomenology allows researchers to obtain knowledge about human beings in a systemic, methodical, general, and critical way. Unlike some phenomenologists, Giorgi (2000) does not believe in verifying the meanings arrived at during phenomenological reduction by returning to those interviewed and asking if the results compiled are true. He defends this practice in 2005, explaining

that all significant findings will be evaluated critically, either by other researchers or by the publication of the findings for the scientific community.

The six basic steps that Giorgi believes are necessary in phenomenological research are outlined here:

1. The collection of verbal data to obtain a concrete description of the phenomenon of interest
2. The reading of the data to gather a sense of the whole
3. Breaking the data into units that have meaning for the phenomenon of interest
4. Integrating the meaning units into related groups and then *intuiting* to find the accurate and essential meaning or *essence* of the phenomenon
5. Organizing and describing the data in language that is meaningful to the community for whom it will be useful
6. Summarizing these meanings before sharing them with the interested community. (Giorgi, 1997, p. 248)

According to Speziale (2003), purposeful sampling is the most frequently used method of sampling for phenomenological research. The investigator or researcher selects participants because they have characteristics that are directly related to the purpose of the study. Careful selection of the sample to be used in the study results in information-rich data for the study. Speziale does not consider sample size as important as it is in other research methods. The purpose of phenomenological research is to describe a lived experience; this description is valid, regardless of the size of the sample.

Study Setting

This phenomenological study was conducted in patient rooms on a 38-bed orthopedic trauma unit at St. Mary's Hospital. Most patients with hip fractures in stable condition are admitted to this unit; the majority of the admissions are from the emergency room. The average length of stay for a hip fracture patient on this unit is four to five days. The study was conducted between September 20, 2007, and January 25, 2008.

Study Participants

Purposeful sampling was used with the participants recruited from patients over the age of 65 who were hospitalized at Saint Mary's Hospital following a hip fracture and who were assessed as cognitively intact by their direct care nurses. Any patient in this group who seemed to have the ability to perceive and articulate meaningful experiences was invited to participate regardless of race, gender, ethnicity, or socio-economic status. The gender and minority mix was dependent on the population from which these patients come. Since the majority of hip fracture patients hospitalized at St. Mary's Hospital come from Olmsted County and surrounding areas, the gender and minority mix reflects that population and the demographics of these areas. Each participant was interviewed once after surgery.

Nursing staff of the orthopedic unit identified potential participants as soon after admission as possible. The investigator approached the prospective participants as soon after they were identified as meeting the criteria of the study. The researcher used a basic recruitment script to guide the meeting. (See Appendix A.) The initial contact took place before or after surgery depending on when the surgery needed to repair the fracture was scheduled. Most of the potential participants were approached prior to surgery, however.

During the initial approach, the investigator explained the study and indicated that the interview would take place after surgery. All cognitively aware patients were invited to participate. Those patients who were willing to participate were approached again between the second and fourth post-operative day. The interview process was explained once more and informed consent was obtained from those who agreed to participate.

During the four-month time frame of the study, 15 potential participants were approached. At the time of the initial contact, 4 chose not to participate, and 11 agreed to be interviewed. However, when approached post-operatively, 8 of the 11 who had expressed interest in an interview were confused and could no longer be considered cognitively intact. As a result, only 3 patients agreed to be interviewed. Only 2 of these completed an interview. The other one did not want the interview taped and asked that the interview be stopped. The participants who completed the interviews were an 86-year-old female and a 73-year-old male. The participant who did not complete the interview was an 88-year-old female.

Data Collection

Data collection consisted of one interview that took place after surgical repair of the hip fracture. The investigator conducted a face-to-face interview with the each participant. The interviews took place in the private rooms of both participants. The interview of the 86-year old female was conducted on the fourth post-operative day. The interview of the 73-year old male was conducted on the third post-operative day. The interviews were audio-taped with a digital recorder. The interviews were unstructured, with open-ended questions asked to elicit the participants' descriptions of their experiences while undergoing treatment for a hip fracture. The investigator developed a

script and a guiding question for the interview based on the phenomenon of interest, the lived experience of a patient while receiving treatment in the hospital after a hip fracture. The guiding question was "What has your experience with a fractured hip been like so far during your hospital stay?" Additional questions were posed when needed to keep participants talking. See Appendix B for the Script and Questions for Participant Interviews, which includes potential subsequent questions.

Data Management and Analysis

Each interview was taped with a digital recorder. Prior to transcription of the recorded interview, each participant was assigned a unique study identification number. All personal identifying information was removed from the recordings and the transcriptions. All information on study subjects is stored in locked file cabinets. Transcripts of the interviews have been stored electronically and information is identified only through a non-identifiable study number. No individual will be identified in any data or in any report. Field notes were completed by the principal investigator immediately after each interview. No information that could identify the participant was included in the notes.

Human Subjects Consideration

Informed consent was obtained from all participants who agreed to take part in the study. This study did not involve the use of drugs or devices, and there were no direct health risks to the participants during the study. Participants were informed that they could request a change in the discussion topic or that they could stop the interview at any time. The only burden to the participants was the time involved in the interview.

The opportunity for participants to express concerns, share feelings, and tell their story may be therapeutic and may have been a benefit to participating in the study. Other patients with hip fractures may benefit from this study because findings will be used to guide future research that will generate much needed knowledge to improve care for this patient population. The lived experiences of the participants provided a rich source of information that will be used to guide future care of patients who have experienced a hip fracture.

Confidentiality was maintained by standard institutional procedures. All information on study subjects is stored in locked file cabinets. Transcripts of the interviews are stored electronically and information is identified only through a non-identifiable study number. No individual is identified in any data or in the final report.

IRB Approval

IRB approval from the Mayo Department of Nursing, the Mayo Clinic, and Augsburg College was obtained before this study began.

Chapter 4: Findings

Data Analysis

Prior to beginning data analysis, Giorgi expects the researcher to begin by *bracketing*, or setting aside any preconceived ideas that he or she has about the phenomenon. This allows the researcher to find the original meaning of the lived experience. Steps 3 through 5 of the six basic steps that Giorgi (1997) considers necessary in phenomenological research are concerned specifically with data analysis:

> 3. The reading of the data to gather a sense of the whole
> 4. Breaking the data into units that have meaning for the phenomenon of interest
> 5. Integrating the meaning units into related groups and then *intuiting* to find the accurate and essential meaning or *essence* of the phenomenon. (p. 248)

The data was analyzed using these steps. Prior to beginning the interviews, the researcher reflected on her perceptions and preconceived ideas of the experience of a hip fracture patient. This allowed her to bracket these perceptions and approach each participant without preconceived ideas of the experience. This bracketing was continued throughout the process of interviewing and data analysis.

Giorgi's method of analysis involves uncovering the meaning of a phenomenon as experienced by a human through the identification of essential themes. To begin this identification process, the transcriptions of all interviews were read carefully to obtain an overall impression of the experience. Then each interview was reread with the researcher looking for essential meanings or meaning units. Each statement in the interview was examined for a meaning unit. According to Giorgi (2000), a statement is a meaning unit

when the researcher determines that there has been a shift in meaning from the previous statement with a new statement.

Themes and Essence

Following the identification of meaning units, the researcher combined the units so that those having a similar content were integrated into a whole. Using this method resulted in five significant meaning units or themes emerging from the transcripts. These themes in turn led to a main essence.

Theme 1: "It really hurts."

Not surprisingly, the first theme involved the pain that the participants experienced. Some descriptions of pain were matter of fact statements: "It hurt, naturally." Others were longer: "If you are perfectly still, the pain isn't bad. It's when you move around that it really hurts." Being moved for procedures and x-rays is also mentioned as a painful experience:

> They tried to move me today and it was still very painful and I hit my head when I fell. So they wanted to have an EKG to see if I have been knocked off my tree, so they took me down to the room where they give or do scans, Cat scans and EKG's and that sort of thing, and moving is hard and they put you on a plastic board and slide you for transport. And when you get down there they have to rearrange you like they do when they rearrange and x-ray people, and it hurts when they rearrange you on the table.

X-ray tables were not designed for patient comfort. This participant described the tables as "hard as a rock." The pain of the X-ray process only exacerbates the pain that the fractured hip causes.

Controlling pain is one of the primary concerns of a nurse on an orthopedic unit. One of the participants noted this as he identified the pain as something that can be controlled:

> They are taking good care of me, I haven't had a serious pain, why if I've got some they are right there with medication. They take care of me, and they are always asking on the scale of 1 to 10, what is it?

Nevertheless pain, even when controlled is still pain. Its presence seems to be woven into most of the descriptions of the experience.

Theme 2: "I couldn't move."

A second theme that is common to both participants is the difficulty that moving entails. Nurses make every effort to get patients walking soon after surgery, which seems difficult for the patient. One participant explained that "It felt like moving a big column." Instead of moving a familiar body in a familiar way, he finds himself moving like a stiff column. The other remarked on her inability to move: "I couldn't move, they just kind of pulled me around." Like the other participant, she finds herself being forced to move with a body that no longer feels capable of movement. Although everyone who works with patients who are recovering from a hip fracture understands the difficulty of moving, these statements help explain just how big an undertaking it is for someone with a recently repaired hip fracture to face this daunting step in their treatment.

Theme 3: "I just want to go home."

A third theme that was expressed by both participants was the frustration they felt with their situation. One explained that she had been through some of this before with a broken pelvis. But now she said "I am frustrated that I can't go home because I just want

to go home." Unfortunately she was going to be discharged the next day to a nursing home where she had recuperated after a previous injury. "I am going to the nursing home which is not good news. I hate it there!"

No one plans to break a hip. Patients who have elective hip replacement surgery are usually prepared for the experience. They have watched the deterioration of the hip and have made the decision for hip replacement. The patient who breaks a hip has no such preparation, and suddenly finds himself in unfamiliar territory. One participant explained his fall and his disbelief that this had happened this way:

> I slipped on some ice near a curb and then proceeded to fall of the curb. Three men had to help brace me to get me up and then they helped me get to my wife's car. We first stopped at the West Union Hospital, and they were unwilling and unable to do the needed surgery so they sent me here. I never expected anything like this to happen to me.

He notes that he will "be ready to move home," but then indicates that he will have to go to a rehab facility. The need for rehabilitation and the long recovery that lies ahead is just one more thing that the patient with a hip fracture must face. The surgery and hospital stay have been traumatic, but now another change is ahead before the participants can even consider going home and regaining their previous life.

Theme 4: "The days blend together."

A fourth theme involved the loss of a sense of time. Both participants used the expression "blend" to describe their feeling that time has lost meaning. "I am losing track on days here, they all blend together." and "I don't really remember . . . the days blend together." For those who work in a hospital, time is tied to routine and work schedules.

However, for patients, especially those who end up in the hospital after a traumatic event, there is little sense of time. In the case of patients with a hip fracture, many factors play a part in this. The trauma and the surgery add to the loss of time. One participant remarked that she had "no memory of waking up or the surgery, just being in this room." The entire experience leads to days that "blend together."

Theme 5: "It felt like I was in a dream."

The fourth theme leads into the fifth theme, which is the overall sense of confusion that has resulted from the hip fracture. When talking about the loss of time, one participant notes that she has "no memory of the fall either." It is also hard to understand many of the activities that are normal hospital procedures. Even blood tests add to the confusion. One participant asked "why do they draw so much blood? Yesterday I think I had blood drawn a least a half a dozen times."

Another participant explained his amazement about the fall and the fracture: "It happened so fast, I talked to others when it happened, but it felt like I was in a dream (long pause...) it is still a little shocking for me." This same participant asks to have a question repeated explaining: "I am feeling a little fuzzy, I don't know if it is because of the surgery and anesthesia or the pain medication." He sums it up well. Everything he mentions could contribute to the confusion he describes.

Essence: "It has been very traumatic and shocking!"

Giorgi's final step is the identification of the essential meanings or the essence of the experience as described by the participants. In some ways all of the themes are interrelated. Pain and difficulty in moving contribute to the frustration the participants felt when they found themselves receiving treatment on an orthopedic floor in a hospital

after a major, life-altering injury. They want to go home but are losing track of time and find themselves confused. However, the words of one participant when asked about his experience provide a perfect description of the main essence of the lived experience: "It has been very traumatic and shocking!" No one plans to break a hip. Given the pain, the confusion, and the inability to return to life as it was before the fracture, it is indeed a traumatic and shocking experience.

Discussion

The purpose of the research for this study was to investigate the lived experience of a patient while receiving treatment on an orthopedic unit after a hip fracture. The essence, that it has been very traumatic and shocking, provides a very clear description of what the lived experience is like. Each of the five themes sheds light on the experience. From the time of the fracture through the entire hospital stay, pain is an issue. While pain can be treated, it is nevertheless a constant backdrop for the experience. Movement, while a necessary part of eventual recovery, is difficult and increases the pain. The patient wants nothing more than to return home and regain his or her former life; yet the rehabilitation that will be needed will delay any hope of returning home for some time. It is not surprising that this realization leads to frustration. In the unfamiliar surroundings of the hospital the patient feels isolated and begins to lose track of time. A final result of all of these factors is a sense of confusion. Between the pain, the pain medication, the surgery, and the plans for rehabilitation, it is not surprising that the patient is confused.

Implications for Nursing Practice

Few experienced orthopedic nurses who have cared for patients with hip fractures would find any of the themes in the description of the lived experience surprising. Nurses

are well aware of pain as an issue. They also know that movement is difficult as well as painful, and that patients want very much to return to their homes. Nor is it uncommon to find that confusion after surgery to repair a hip fracture. However, taken as a whole, the description of the lived experience has some troubling implications. The picture painted is far greater than each individual theme would describe. Of greatest concern is the presence of confusion, even in those patients who do not exhibit obvious confusion. This study shows that confusion is far more prevalent than many nurses realize. The participants who were interviewed for this study were assessed as cognitively intact postoperatively. Yet they both described a certain degree of confusion, although they were capable of participating in the interview. One participant described himself as a "little fuzzy." Both felt that they had lost track of time. Moreover, their responses to questions showed some of this confusion as a lack of ability to concentrate. Both participants paused frequently while recounting their experiences, seeming to need time to gather their thoughts. Questions needed to be repeated in some cases.

In addition to the evidence of confusion in the interviews, the difficulty of finding participants to interview is significant by itself. During the four-month period that this study covered, 15 potential participants were identified in the group of patients who presented with a hip fracture; 11 of these agreed to be interviewed after surgery. All of these were considered cognitively aware prior to surgery. However, after surgery, 8 of the 11 were too confused to participate in an interview. Had the interviews been scheduled for a later time, the confusion might have disappeared. Given the current length of stay allowed for treatment of a hip fracture, however, it seems obvious that in many cases nurses are doing discharge planning with patients who are confused to some degree.

What is even more troubling is that in many cases this confusion is not immediately obvious. Both of the participants in this study seemed aware of what was going on around them, but some confusion became obvious during the interview.

Nurses on an orthopedic floor are under constant pressure to keep the hospital stays of patients with hip fractures within the Medicare guidelines. This study points out some issues that need to be considered. First, confusion may be present after surgery even when it is not present upon admission to the hospital. Furthermore, confusion may be present to some degree even in those patients who seem cognitively intact after surgery. One of the biggest concerns is the timing of discharge planning. Most of the process takes place after surgery. Since confusion may be an issue at that time, this possibility should always be considered during the planning. Ideally, discharge planning would not be completed during the immediate post-operative period, but given the Medicare length-of-stay mandates, that is not an option. Recently, there has been an effort to improve the length-of-stay statistics for the orthopedic unit where this study took place. As a result, the discharge planning process is now started immediately after admission and prior to surgery. Patients may be able to make better decisions before surgery, and it makes sense to give them time to consider all of the issues that they will need to face when they leave the hospital. However, as the essence of the lived experience revealed, a hip fracture is a very traumatic and shocking experience. Everyone involved in care of these patients needs to remember the perspective, cognitive abilities, and discharge needs of the patients when helping them plan for the future.

This description of the lived experience of a patient while receiving treatment on an orthopedic unit after a hip fracture provides information that may not be readily

apparent to the orthopedic nurses who are providing care. It is hoped that this information will enhance the care they provide and lead to improved outcomes for the patient.

Chapter 5: Discussion, Issues, and Recommendations

Discussion

This phenomenological study provides significant information for nurses who care for patients with hip fractures. Knowledge of the lived experience of the patient will help both orthopedic nurses and nursing leaders. First, this study highlights the constant pressure both orthopedic nurses and leaders face as they try to balance the needs of the patient with the financial constraints of reimbursement policies. It is a constant concern for nursing leadership in all aspects of hospital practice, but especially those who care for patients with hip fractures. Transformational leaders are caught in a struggle for this balance. Watson (2000) recognizes this struggle and reminds leaders that compassionate administrators enhance caring by listening to others, listening not only to what is being said but also to the spirit of what is being said. She reminds nursing leaders that "authentic leadership" will always "sustain systems of caring and healing" (p.1). As nursing leaders struggle to find balance, the stories of the lived experience of patients with hip fractures will remind them the patient is at the center of the struggle.

Second, this study emphasizes again that caring for the patient remains the first calling of all nurses. No matter how much time is consumed by the administrative tasks that are part of what Watson calls the Trim, caring remains the heart and soul of nursing. In her Theory of Human Caring, Watson (1999) talks about the need for nurses to truly know their patients; this knowledge leads them to form caring relationships through which they can "preserve human dignity, wholeness, and integrity" (p. 102). Gaining an understanding of the lived experience of the patient with a hip fracture will provide some

of the knowledge orthopedic nurses need to provide the care a patient with a hip fracture needs to maintain dignity and become whole again.

Issues for Advanced Nursing Practice

The purpose of this thesis is to show how transformational nursing leaders can use information gained through phenomenological research to influence patient care. Using the lived experience of the patient to enhance and improve care is a significant outcome. However, nursing leaders can also influence patient care by advocating for change in national medical and Medicare policies. Information from this study highlights the problems caused by current Medicare policies that require shorter hospital stays after treatment for a hip fracture.

Nurse managers on an orthopedic floor are under continual pressure to try to make sure that patients with hip fractures do not exceed the limits imposed by Medicare and Medicaid. Currently that means that a patient is to be discharged within four or five days. Assuming that surgery occurs on the second day of the hospital stay, it is very likely that many patients will be discharged from the hospital while they are somewhat confused. It also means that many patients will not be able to understand and participate fully in the discharge planning arrangements that must be made.

Shorter stays have also resulted in most patients being discharged to a nursing home or rehabilitation facility. This second relocation will only exacerbate any confusion that exists at the time of hospital discharge. Rehabilitation from a hip fracture is a long process that requires hard work and full attention on the part of the patient. Mental confusion is a detriment to this process and could easily result in a longer stay in the nursing or rehabilitation facility. The longer stays in a care facility will often have a

negative impact on the eventual recovery of the patient. Boockvar et al. (2004) found that patients who were relocated to other facilities after hospital stays for hip fracture repair had poorer outcomes than those who returned home, regardless of their condition at the time of the injury.

Unfortunately, neither hospitals nor nursing leaders have control over this issue. Failure to meet the limits on hospital stays imposed by Medicare results in a significant loss of reimbursement for the hospital. More study is needed on the effects of these shortened stays both on patient outcomes and on long term cost savings. If the shorter hospital stay results in a patient being discharged while still confused, a longer period of rehabilitation will probably be needed. How do the costs of the shorter stay and longer rehabilitation compare to the costs of a longer stay with less needed rehabilitation time? How does early discharge impact the physical outcomes and quality of life of the patient who has experienced a hip fracture? Are patients who are discharged early more apt to be readmitted at a later date? Are they more apt to need home health care assistance once they return home? Is this really cost effective? Perhaps a longer hospital stay would result in fewer health care expenses after discharge? Answers to these questions could be used to lobby for changes in Medicare policy.

Recommendations for Further Research

This investigation raises the issue of post-surgical confusion in patients with hip fractures. While the presence of confusion may not be a surprise to orthopedic nurses and nurse managers, the number of patients who were approached prior to surgery for this study but were unable to take part after surgery because of confusion is surprising. So too is the possibility of underlying confusion in those patients who seem cognitively intact.

This study involved a small number of participants. Since this was a phenomenological study, the small size of the sample does not invalidate the information as it would in other research methods. As Speziale (2003) points out, the purpose of phenomenological research is to describe a lived experience; this description is valid, regardless of the size of the sample.

However, the numbers are not adequate to draw any conclusions about the occurrence of post-operative confusion. Yet given the troubling possibility that post-surgical confusion is frequent, it would be worthwhile to gather additional information about the issue. The issue of post-surgical confusion is also involved in the difficulties with the current Medicare reimbursement policy for hospital stays after treatment for a hip fracture. Additional investigation of this problem would be helpful to those who advocate for policy changes.

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Appendix A

Recruitment Script for Potential Study Participants

I would like to talk to you about a research study that I am doing as part of my master's degree thesis in Nursing at Augsburg College. I am interested in the hospital experience of a patient who has had a hip fracture. You were selected as a possible participant because you are receiving treatment for a hip fracture at St. Mary's Hospital. The purpose of this study is to develop a better understanding of what it is like to be a patient on an orthopedic unit after a hip fracture.

If you agree to be in this study, I will ask you to take part in a face to face interview with me during your hospital stay at a time convenient for both of us. Interviews will take place in a private room. All interviews will be audio-taped with a digital recorder. You will be asked to talk about your experience with a hip fracture while answering the question: "What has your experience with a fractured hip been like so far during your hospital stay?" All of the information you share will be confidential. Nothing you share will be placed in your medical records or shared with any other medical personnel. The time involved will vary but should be less than an hour. There are no direct health risks to you during this study. It is possible that the discussion of your experience with a hip fracture may make you uncomfortable. You can ask me to change the discussion topic or you may stop the interview at any time that you don't want to continue.

You might find it helpful to be able to express your concerns about your care and injury, share feelings, and tell your story. Often it helps to talk about what you are going through. I hope that my study will help other patients with hip fractures. The findings

will be used to guide future research and will help the nursing staff improve care for patients with hip fractures.

Is there more information I can give you? Would you be interested in participating in this study? You are certainly under no obligation to take part in this study. Whether you choose to participate or not will have absolutely no effect on your medical care here at Mayo.

Appendix B

Script and Questions for Participant Interviews

Mr/Mrs./Miss XXX, thank you very much for agreeing to be interviewed for the study that I am doing. The information that you, and other patients, give me will provide nurses on orthopedic units with a better understanding of what someone who has fractured a hip experiences while in the hospital.

Let me explain something about the kinds of questions I will be asking you. Although I have taken care of many patients with hip fractures, I have never experienced one myself. Therefore I want you to tell me in your own words about your experience. I have not read your medical records, except to verify that you had a hip fracture. Therefore, I know nothing about how you fractured your hip, when you came to the hospital, or even how your fracture was repaired. Therefore, I am going to start by asking you what you remember about the fracture and your admission to the hospital. I may ask you to explain some things a little more.

I am going to be tape recording this interview. Everything that is recorded will be completely confidential. Nothing that you say will go into your medical record, and I will not share this information with any or your doctors or nurses. Your interview will be transcribed - by that I mean someone will type what you and I say. However, your name will not appear - you will be given a number only. When I use information from your interview in the report I prepare, your name will not appear.

If at any point in the interview, you need a break, let me know and I will stop the tape and the interview and help you in any way I can. If you do not want to answer a question, you do not have to. If for any reason you want to stop the interview completely,

just tell me and we will stop. Do you have any questions or concerns about this process at this point?

Broad Opening Question

What has your experience with a fractured hip been like so far during your hospital stay? (If this fails to elicit a long response, the following sets of questions may be used.)

Questions about care just before and just after surgery

1. What happened immediately after surgery? What do you remember about waking up? Tell me more about the experience.
2. Can you give me an example of anything that happened that you did not understand or feel prepared for?
3. Can you think of a time that you may have felt overwhelmed by everything that has happened? Can you describe these feelings for me?

Post-Surgery Care

4. When did you first get up after surgery? How did you feel about trying to move at this point? Can you describe these feelings for me?
5. How do you feel as you look ahead to leaving the hospital?