

**ENHANCING THE CARE PATHWAY FOR
OLDER PATIENTS WITH FRACTURED FEMUR:
AN ACTION RESEARCH STUDY**

by

Mary Grace Mifsud

A submission presented in partial fulfilment
for the requirements of the
University of South Wales / Prifysgol De Cymru
for the degree of Doctor of Philosophy

February, 2018

ABSTRACT

An ageing population with a decrease in birth rate, a decline in workforce, plus an increase in the incidence of falls in older adults and the changing family caring role in Malta is causing more demands on the healthcare system whilst exacerbating problems in providing optimal healthcare delivery. This study focused on identifying ways in which to improve the patient journey for those who have suffered from fractured femur from admission to hospital until recovery and discharge into the community. A Participatory Action Research (PAR) Cycle was conducted which was guided by the Habermas (1984) Theory of Communicative Action. This PAR Cycle followed three phases which incorporated a basic AR routine cycle of “LOOK, THINK and ACT” (Stringer, 2014) and included the following phases:

In **Phase 1 (LOOK Phase)** a three month quantitative data (n=61) was selected to obtain baseline data. One-to-one interviews (n=45) with stakeholders were also conducted to identify shared concerns. In **Phase 2 (THINK Phase)** the research facilitator communicated with a PAR group and following data analysis from Phase 1, it was decided that there was a need for more information-giving during the patient journey. A booklet was developed, implemented and evaluated in **Phase 3 (ACT Phase)**. During this final phase, semi-structured interviews with patients and their ICs (n=10) as well as two focus groups with HCPs (n=8; n=6) were organised to evaluate the use of the information booklet.

A key finding of this study was that participants viewed their hospital experience as good but they needed more information on their care pathway specifically in relation to their surgery, rehabilitation and discharge. Following the implementation of the information booklet, findings showed that all stakeholders viewed the booklet as beneficial, as a good information source and guide following the older patient’s discharge. HCPs reported that it should not substitute verbal explanation but be complementary to further enhance the patient care pathway. Finally, there was a recognised need to address issues for clinical practice, hospital management and future research to further enhance the journey of fractured femur patients from admission until recovery and discharge into the community.

*Dedicated to my parents
John and Mary
for their endless love and encouragement.*

*You nurtured and guarded me
and trained me with great care.
You taught me how to love
and respect others.*

*Every time I have needed you,
you were constantly there for me.*

*Dedicated to and in memory of
Professor Donia Baldacchino*

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to a number of people who have helped me during this journey. My deepest gratitude goes to the Director of Studies Professor Joyce Kenkre, Dr Carolyn Wallace and late Professor Donia Baldacchino, for their guidance, constant support, encouragement and insightful constructive criticism throughout the completion of this study.

Special thanks go to all those patients and their informal carers who accepted to participate in this research study. I would also like to express my gratitude to all the healthcare professionals who have supported me and have made this study possible. Without their support and participation, this study would not have been possible.

I am also grateful to my colleagues and Mr Brian Chircop at the Orthopaedic Ward since without their continuous support and encouragement, I would not have been able to achieve my goal. My appreciation also goes to Mater Dei's hospital management for their continuous support throughout this study.

I would also like to thank the field expert Mr Reginald Aquilina and Ms Kristin Sammut Henwood for helping with the rigour of this study. I am also grateful to Ms. Cathy Farrugia for her patience and dedication in proofreading my work.

I also owe my deepest gratitude to the experts in the English language Ms Lilian Oliva Mifsud and my brother Mr George Mifsud for guiding me with the Maltese translations and the proofreading of the information booklet as well as my work. Without their support and encouragement, I would not have been able to achieve this important target in my life.

I would once again like to thank all my family especially my parents John and Mary who have continuously encouraged me to reach this important goal in my life. I am also grateful to my brother Joseph for his support throughout. My thanks also go to my dear friend Ms Connie Farrugia, for her help, encouragement and support.

Last but not least, I wish to thank all my friends of MUSEUM with whom I spend most of my time, for their patience, prayers and encouragement.

DECLARATION

I hereby, declare that I myself have carried out this dissertation and this is entirely my own work, except where specific reference is made. I declare that no material contained in this dissertation has been used in any other submission for any academic award.

Mary Grace Mifsud (Candidate)

Date: _____

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LIST OF ABBREVIATIONS

ADL	Activities of Daily Living
AR	Action Research
CAQDAS	Computer assisted qualitative data analysis software
CI	Confidence Interval
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CLN	Community Liaison Nurse
EHHF	European Hospital and Healthcare Federation
EU	European Union
FG	Focus Group
GP	General Practitioner
HCP/s	Health Care Professional/s
HAA	Hospital Activity Analysis
IC/s	Informal Carer/s
MDT	Multidisciplinary Team
MMDNA	Malta Memorial District Nursing Association
MRSA	Methicillin Resistant Staphylococcus Aureus
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NSM	Neuman Systems Theory
NSO	National Statistics Office
OR	Odds Ratio
OT/s	Occupational Therapist/s
PAR	Participatory Action Research
PAG	Participatory Action Group
PDN	Practice Development Nurse
QUAGOL	Qualitative Analysis Guide of Leuven
RCTs	Randomised Controlled Trials
RR	Risk Ratio
SD	Standard Deviation
SMD	Standardised Mean Difference
SRs	Systematic Reviews

LIST OF ABBREVIATIONS (cont.)

SIGN	Scottish Intercollegiate Guidelines Network
SPSS	Statistical Package for Social Sciences
TCA	Theory of Communicative Action
TRIP	Turning Research into Practice
UK	United Kingdom
US	United States
WHO	World Health Organisation

GLOSSARY

Discharge: Discharge was defined as “the release of a patient from a provider’s care, usually referring to the date at which a patient checks out of a hospital” (WHO, 2004, p.22).

Discharge planning: Discharge planning was also defined as when admitted patients’ needs are foreseen and prearranged prior to discharge (WHO, 2004).

Fractured femur: For the purpose of this study, the focus is on patients with hip fractures involving the upper femur, i.e. fractures which involve the neck, head and trochanteric area. The terms ‘hip fracture’ and ‘fractured femur’ are used interchangeably.

Informal carers: Any person who is assisting the patient without any payment, such as a family member/s (spouse, children and siblings). A caregiver was defined as a person who offers support and assistance with various activities to persons with long-term needs or persons who are old (WHO, 2004).

Multidisciplinary team: Nurses, nurse assistants (care workers or nursing aides), doctors and orthopaedic surgeons, geriatricians, physiotherapists, occupational therapists and a social worker.

Older patient: An older person over 65 of either gender admitted to the acute hospital in Malta with fractured femur. The older person was defined as, “a person who has reached a certain age that varies among countries but is often associated with the age of normal retirement” (World Health Organisation [WHO], 2004, p.42).

Patient journey: The patient journey from admission to the acute hospital until discharge from hospital or rehabilitation hospital to home.

GLOSSARY (cont.)

Rehabilitation Phase: Period of regaining independence from admission to hospital, discharge through transfer to rehabilitation hospital or home. Rehabilitation was also defined as: “A proactive and goal-oriented activity to restore function and/or to maximise remaining function to bring about the highest possible level of independence, physically, psychologically, socially and economically. It involves combined and coordinated use of medical, nursing and allied health skills, along with social, educational and vocational services, to provide individual assessment, treatment, regular review, discharge planning and follow-up. Rehabilitation is concerned not only with physical recovery, but also with psychological and social recovery and reintegration (or integration) of the person into the community.” (WHO, 2004, p.49).

Research facilitator: The researcher was the facilitator. Gaffney (2008, p.9) states that “one of the roles of a research facilitator or mentor is to understand the varying demands on team members so as to maximise the opportunities for contribution without overwhelming participants.”

Stakeholders: All the collaborators to include older patients over 65 admitted with fractured femur, their Informal Carers (ICs) and HCPs who were members of the Multidisciplinary Team (MDT).

CHAPTER 1

INTRODUCTION

1.1 Introduction

The aim of this chapter is to present an overview of the research problem and the importance of researching it. This chapter presents the reader with a concise description of Malta's demography, as well as the island's healthcare system. It also highlights the complex nature of fractured femur patient care, as well as outlining the researcher's experience in the field of orthopaedics. A brief description of the various chapters within this dissertation is also given.

1.1.1 Overview

Hip fractures are usually the result of falls which are the second leading cause of injury or death worldwide with the greatest number of falls in older adults over 65 years of age (World Health Organisation [WHO], 2010).

Hip fractures involve a break in the stability of the femur which can occur at the neck, head and trochanteric area of the femur, at the shaft of the femur and at the knee known as supracondylar and condylar fractures (Russell, Williams & Bulstrode, 2004; Smeltzer & Bare, 2004). A hip fracture may include the acetabular areas since the hip is a 'ball and socket' joint (Altizer, 2005; Parker & Johansen, 2006). These types of fractures are more likely to occur in elderly patients rather than in adults or in children.

In 1990, worldwide epidemiological data regarding hip fractures amounted to 1.66 million. This is expected to rise to 6.26 million by the year 2050 (Kannus *et al.*, 1996).

1.1.2 Risk factors

Relevant literature shows that the main risk factors for falls are biological (age, gender and race), behavioural and environmental, as well as socioeconomic risk factors (WHO, 2007a). Age and frailty levels bring about an escalation of the frequency of falls and those older persons residing in nursing homes are likely to incur more frequent falls than those living in the community (WHO, 2017). Other causes of hip fractures are cardiovascular disorders, neurological conditions, visual impairment and osteoporosis leading to femoral fractures even from just a standing height (Kammerlander *et al.*, 2012). The risk factors that are associated with hip fractures and the consequences on the older population were found to be severe, whilst the healthcare costs tend to be high (Peleg *et al.*, 2011).

1.2 Fractured femur patient care: A historical perspective

The first explanation about fractures of the proximal femur was presented between the years 1818 and 1838 in a book by Cooper and Travers dividing fractures into intracapsular or extracapsular (Bartonicek, 2002). More details about the history of fractured femur treatment is presented in Appendix 1.

1.3 Fractured femur patient care: Current treatment and outcome

Pountos and Giannoudis (2016) state that the most common type of fracture is the intertrochanteric which accounts for a significant percentage ranging from 33% to 50% of the proximal fractures occurring in older persons with a higher prevalence in females with osteoporosis.

The NHS Institute for Innovation and Improvement U.K (2010) explains that hip fracture following a fall is the most serious injury amongst the older population, with a mortality of 10% after a month after the fall, 20% at four months and 30% at one year. Twenty per cent of these patients need long-term care after surgery and another 30% do not regain their pre-fracture functional status and many who recover experience loss in mobility and independence (NHS, 2010).

1.4 Fractured femur patient care: An international perspective

Whilst there is an increase in life expectancy, a major issue to be found in many trauma centres in several countries in the twenty-first century is the rise in the incidence of older patients admitted with hip fractures (Clunie & Stephenson, 2008; Maher *et al.*, 2012; Hickman, 2015; Pountos & Giannoudis, 2016). Femoral fractures are amongst the leading causes of mortality and disability and cause high rates of institutionalisation amongst the older population in developed countries (Handoll, Queally & Parker, 2011; Kim *et al.*, 2011; Kondo, Zierler & Hagino, 2011; Al-Maqbali, 2014).

1.4.1 World demographics and relevant statistics

World demographic changes in the age group of 60 and over are increasing (from 12% in 2015 to 22% in 2050). Population projections in this age group are expected to increase to two billion by the year 2050 from 900 million in 2015 (WHO, 2015).

The incidence of older patients suffering from a fractured femur in the U.K. was about 75,000 every year, with estimates predicting that this will increase to 101,000 by the year 2020 (National Institute for Health and Care Excellence, 2011). In the United States (U.S.) the incidence of hip fractures in older patients over the age of 80 was 1,140 per 100,000 people, whilst in Japan, the rate was 642 per 100,000 (Kondo, Zierler & Hagino, 2011).

In Australia, Canada, Ireland and the United Kingdom (U.K.), an increase from 1.6 to 3.0 per 10,000 population in this age group was reported in hospital admissions due to falls (WHO, 2007b). Furthermore, Wyller *et al.* (2012) estimated that 30% of older people over 65 who live in the community in the Scandinavian countries experience a fall each year with half of them falling over twice or even more frequently.

1.4.2 Cost of fractured femur treatment across the world

In 1999, in the U.K., the annual cost of patients with fractured neck of femur was estimated to be £1.7 billion (Youde *et al.*, 2009). In the National Health Service (NHS) in Scotland, it is estimated that the cost is about £73 million per year

(Scottish Intercollegiate Guidelines Network [SIGN], 2009). These costs range between an average of €944 per hip fracture in Finland (Nurmi & Luthje, 2002) to \$6,700 (€5,900) per hip fracture in Western Australia (Hendrie *et al.*, 2004). In addition, it is predicted that costs due to falls resulting in hip fractures in older adults over 65 years of age in Western Australia are nearly \$90 million per year and this is predicted to double by the year 2021 (Hendrie *et al.*, 2004). In the U.S., the costs of hip fractures are the most expensive type of injury, costing around \$18,638 per patient (Roudsari *et al.*, 2005).

1.5 Fractured femur patient care: A local perspective

Malta is situated in the Mediterranean Sea and is 93km south of Sicily and nearly 300km north of Libya and 288km east of Tunisia (Department of Information, Malta, 2010). Its capital city, Valletta is its cultural, administrative and commercial centre. The island is approximately 316km² (122 square miles) in land area, making it one of the smallest and most densely populated countries in the world (Conrad, Christie & Fazey, 2011). It consists of numerous small towns and villages, which together form one large urban zone. Even though the island is so small, it enjoys its own language and more than nine-tenths of the population are Roman Catholic (Busuttil & Briguglio, 2017). Malta has been characterised by strong family structures which provide a significant proportion of the care required for ailing family members. In fact, in times of need, older adults primarily turn to their own families (Troisi, 2013). This will be further discussed in Section 1.5.6.

1.5.1 Local demographics

According to the 1842 census, Malta's population was 114,499 which increased to 425,384 by 2014 (National Statistics Office [NSO], Malta, 2014). This shows that the island's population increased by three and a half times in just 172 years. In addition to this, projections for Malta's ageing population indicate a steady increase from 32.7% in 2020 to 40.5% by 2030, exceeding the EU average which is expected to be 39% (Azzopardi-Muscat *et al.*, 2017). In Malta, life expectancy at birth is higher than other European countries and males are predicted to live till the age of 80 (as opposed to 78 for the EU), whereas females are expected to live up to 84 (compared to 83 for the EU) (Azzopardi-Muscat *et al.*, 2017).

1.5.2 Local healthcare, hospitals and care facilities

The Maltese Government provides a comprehensive health service to 425,384 residents (NSO, 2014) that is free at point of use and is funded through general taxation and national insurance. All citizens have access to preventive, investigative, curative and rehabilitative services in government health centres and hospitals.

There is one local acute hospital and one state rehabilitation hospital, supported by private agencies. There is a similar set-up on Malta's sister island, Gozo, but on a smaller scale. Licensed church homes, private nursing homes, governmental long term care wards are also available. The acute general hospital is a teaching hospital with 928 inpatient beds. The orthopaedic department is divided into two trauma wards and a 24 bedded elective ward. There is a total of 45 beds in the trauma wards; one ward consists of 21 beds whilst the other is a 24-bedded ward. The latter is where this study was conducted.

1.5.3 Local statistics

Statistical data indicates that older people over 65 years of age are found to be at risk of falling below the poverty level with males (20%) being more at risk than females (17%) (NSO, 2012).

Statistics show that Malta, along with another six countries, was found to have a high risk of hip fractures occurring in females and a moderate risk occurring in males. It was placed in tenth place when incidence rates were evaluated amongst 63 countries (Kanis *et al.*, 2012). Maltese statistical data indicates a rise of 19% of patients over 65 admitted to hospital with a fractured femur between 2010 and 2015 (Hospital Activity Analysis [HAA] Malta, 2016). It is noteworthy to highlight that the above data exhibited an increase in the incidence of hip fractures in the year 2012. The increase of hip fractures throughout that year was attributed specifically to an increase in the age group between 75 and 79. In the same year, there was also an increase in the incidence of hip fractures amongst the 80 to 84 age group with a similar increase during the following year.

A local study showed that 47% of older patients died within three years of their fall with a prevalence of 69% in females, 13% died within three months with the

majority of them having an intertrochanteric femoral fracture and 26% died within the first year of their hip fracture (Grech & Cuschieri, 2016).

1.5.4 Cost of fractured femur treatment in Malta

The costs in Malta of a hip fracture average around €5,183 per patient with an average stay of 11 days without considering the negative effect it has on the quality of life of patient, family and society (HAA Malta, 2015; Cuschieri, Grech & Gatt, 2016). This is comparable with the hospital length of stay in other countries which varies from 4 to 8 days in Switzerland (Seematter-Bagnoud *et al.*, 2006) and 7.5 days in the U.S. (Roudsari, 2005). Besides hospital costs and the average length of stay, one should also consider the subsequent health and social care costs needed following discharge from hospital and costs met by the patients' family caregivers (SIGN, 2009).

1.5.5 Local issues

The principle health challenge in Malta is obesity where 25% of the adult population and 27% of children aged between 11 and 15 are obese, a rating which is the highest amongst European countries (Azzopardi-Muscat *et al.*, 2017). This problem of obesity has led to a high prevalence of Type 2 Diabetes when compared with other European countries (Azzopardi-Muscat *et al.*, 2017). The authors contended that chronic illnesses associated with obesity [diabetes, circulatory disease and stroke], unhealthy ways of living and frailty related with ageing remain the main challenges facing the Maltese population.

1.5.6 Socio-political and cultural context of the study for the participants

As a population, the Maltese people are reknowned for the level of care they dedicate to their elderly relatives. This is evident when one observes the close connections people maintain with their family (Grima, 2006 & Troisi, 2013). Until recently, children used to live with their parents until they got married. Parents often assist their children with their needs, such as helping their children to buy a house, assisting them with wedding expenses and/or buying a car. Children also have the tendency to keep a close relationship with their grandparents. Maltese families tend to meet regularly for quality time, generally at their parents' house and especially during village feasts, weekends and holidays. Furthermore, studies show that the

family still acts as the main provider of care for the elderly and the ‘exchange of obligations,’ which refer to the responsibility family members feel towards their parents, are the foundations of family relations (Troisi & Formosa, 2006, p.9).

Although the Maltese family tends to maintain family relations, the current demands on members are disturbing these age old cultural traditions. This issue has been acknowledged by Troisi and Formosa (2006). These authors explain that it is becoming a more frequent occurrence, that when it comes to supporting older adults, especially those who are very frail, the traditional role of the Maltese family is often affected by financial, social and psychological constraints. This can cause a great deal of tension when it comes to providing support for elderly members of a family.

The traditional family organisation is therefore changing. This is generally a result of a reduction in family size, relatives becoming old themselves, more females joining the work force, an increase in older frail family members and more elderly relatives residing in long term care institutions (Grima, 2006; Troisi, 2013). As well as these issues there are others which, exacerbated by the changing family caring role in Malta are creating serious problems for the healthcare system, namely; an ageing population coupled with a decline in birth rate and in the workforce; the changing pattern of illness from infectious diseases to chronic illnesses and an increase in the incidence of falls in older adults. Hence, there are various factors preventing family members from becoming permanent carers for their family members. This, in turn, brings about some serious issues when providing optimal healthcare delivery.

Troisi ascertains that:

... despite recurring misgivings about the commitment of the family to care for its older members, it is generally accepted that the central role played by the family, especially by women, as principal providers of care, is still relatively maintained and the exchange of obligations are, by and large, still the basis of a good number of family relations (Troisi, 2013, p. 279).

When it comes to defining the cultural aspects of care in Malta in relation to family support in older patients, one might assert that generally, in times of need, older adults still turn to their children or relatives for assistance. This is demonstrated in

the fact that older patients in Malta are usually admitted to the emergency department accompanied by their relatives. Therefore, older patients turn primarily to their close family members, rather than to friends or neighbours. This could be because they trust their closest relatives with their health and well-being. Another rationale for having close family members with them whilst being hospitalised could be to ensure that information given to them is clearly understood. Having their relatives with them helps the older adults by supporting them to understand the information that is being imparted to them and to reassure them. The relatives can then act as a point of reference at a later stage.

Older patients in Malta still claim to face challenges with communication (Grima & Sammut, 2010; Woodhead, *et al.*, 2015). In a study conducted in Malta for the first time by Grima and Sammut (2010), the authors highlighted that one of the domains that needed to be addressed was the level and quality of communication between patients and Health Care Professionals (HCPs). Sometimes, communication does not even take place in a language the patients understand and this causes some serious issues. The authors maintained that efforts to improve this situation should not entail a great expense but would surely improve patients' experience in the local hospital.

The researcher's own previous experience has shown her that there is a continuous increase in the number of older patients undergoing hip fixation, following a fall. While reflecting on practice, during her duty in the operating theatres, the researcher used to communicate and ask patients' questions mainly about the preoperative check list. She discovered that older, frail patients in Malta seemed to generally request information about their procedure and recovery while already in the operating theatres. The researcher often found herself assisting patients' perioperatively who were very anxious and some of them had received very little information about what was happening to them.

Such issues raise a number of questions such as: Why are patients asking questions at this very vulnerable time? Are patients being informed sufficiently prior to being taken to the operating theatre? Are HCPs, with particular reference to those nurses who are constantly caring for the patient, asking for feedback to ensure that the patient has understood everything? Is the information given not clear enough?

The researcher believes that there are very likely to be various reasons for this lack of information and understanding. She places a great deal of importance on the cognitive status of the older individual, the timing of information-giving, as well as power inequality. Throughout this study, she will consider ways in which the patient care pathway can be improved upon.

A problem that certainly exists with the older patients' and HCPs' communication is the language barrier, use of jargon, hearing difficulties and HCPs who assume that patients have understood the information given. Locally, HCPs also believe that older adults do not have the knowledge and the skills to question HCPs as much as younger patients do. This could be because of high illiteracy rates in older adults in Malta. On the other hand, frail, older Maltese patients trust and accept the information given by HCPs. This was supported by Grima and Sammut (2010) who found that 95% of the Maltese patients interviewed expressed confidence and trust in the doctors and nurses who were caring for them. In addition, culture influences practice since the older patients still obey doctors' orders as they believe that the doctor knows best. However, this is not the same with the younger generation as more people are questioning the actions of HCPs. Some are going as far as suing the health department if they feel that they did not receive the level of service they expect from such an institution.

Another issue which needs to be considered is the influence that the medical profession in Malta retains. Literature shows that doctors have owned clinical autonomy in work practice and have a high social status, whilst patients accept their advice and medical paternalism (Allsop, 2006; Malterud, 2010 & Tousijn, 2012).

HCPs may have a number of characteristics that place them in an influential position when it comes to their dealings with patients. These features could be knowledge, their professional status, their physical health and access to the patients' personal information which all may cause imbalance in the distribution of power (Allsop, 2006; Malterud, 2010 & Corless, Buckley & Mee, 2016). Although this power position can be occupied by HCPs, either consciously or unconsciously, the frail older patient may suffer. To illustrate this, various HCPs such as doctors and nurses present their arguments in favour of themselves or hospital rather than for the benefit

of the patient. Besides, there is the tendency that as HCPs, it is expected to receive patient information freely but when it comes to sharing personal information with the patient (which may be of help to the patient), there is the fear of crossing professional boundaries. There are also times when information-giving and communication becomes more procedural rather than participative between the patient and the HCPs. Finally, the medical profession generally dominates patients care through knowledge obtained from research, transmission of knowledge through education and the application of the knowledge in daily practice (Salter, 2000 as cited by Allsop, 2006).

1.6 Fractured femur patient care: A complex issue

The rehabilitation of patients admitted to hospital with a fractured femur is complex and challenging because an equilibrium needs to be found between the need to uphold their physical skills and their limited capability to do so (Olsson, Karlsson & Ekman, 2007; Healee, McCallin & Jones 2011).

Hip fracture for the independent aged individual may mean some loss of previous mobility, whereas for the frail patient it may lead to **institutionalisation** together with pain, confusional episodes and ‘disruption to complicate an already distressing illness’ (SIGN, 2009, p.1) with the probability of psychological distress. Zammit *et al.* (2016, p.39) determined that “80% of older women say they would rather die than experience the loss of independence and quality of life associated with a hip fracture.”

Furthermore, older patients experiencing a hip fracture often have other medical conditions and physical difficulties related to their age which may influence recovery (Watters & Moran, 2006; Handoll *et al.*, 2009; Handoll & Parker, 2010; Merten *et al.*, 2011; Rostagno *et al.*, 2013; Al-Maqbali, 2014). Analysing older patients admitted with fractured femur, Brotemarkle *et al.* (2015) reported that the average of **comorbidities** per patient was 2.29 and the severity of the injury showed a third of the sample (34%) who suffered mild to moderate injuries whilst the other two thirds (66%) experienced severe injuries. Apart from physical injuries, common

comorbidities usually reported were cardiovascular, respiratory diseases and rheumatic disorders (Sivertson, Oberg & Sernert, 2010).

Research indicates that there is an increased **need for rehabilitation** services amongst the hospitalised older population. This is demonstrated by Nguyen-Oghalai *et al.* (2008) whereby discharge of patients with hip fracture from the acute care to inpatient rehabilitation doubled from 12% to 24% in four years. Apart from the financial costs expended on hospitalisation and rehabilitation, patients experience **psychosocial problems** due to loss of control over their health and loss of autonomy. Bowman *et al.* (2001) argues that tension exists between older patients' autonomy and service dominance in various aspects of care. Older patients admitted with a fractured femur become frail, are in pain and shocked due to an accidental fall which requires urgent, unplanned hospitalisation and which may also cause cognitive problems. The difficult part of decision-making for frail older patients and their families is usually when they need to decide on discharge date and destination (Foss & Askautrud, 2010; Popejoy, 2011). In spite of this, a patient:

... has the right for support and enough information to participate in the management of one's condition. This should include how and when to take medications and how to access other support services that can help improve the patient's well-being (Maltese Charter of Patient's Rights and Responsibilities, 2016, p.10).

The **discharge planning process** in the aged cohort is complex because of the number of people involved, together with the challenges of providing after care and other services which can increase their long-term needs (Williams, Nolan & Keady, 2009; Popejoy, Moylan & Galambos, 2009; Pellett, 2016). HCPs also encounter problems with designing robust discharge plans leading patients to a safe and successful return home (Popejoy, 2008). Successful discharge is crucial in the provision of good quality healthcare in an ageing society (Tanaka *et al.*, 2008; Satomi *et al.*, 2009) and in the sustainability of healthcare systems (Gholizadeh *et al.*, 2016). A coordinated multidisciplinary team approach in discharge planning from admission across to the community is a challenging process (Popejoy, 2008; Lin *et al.*, 2009; Goldberg & Robbins, 2011) and should emphasize patient

involvement, early rehabilitation and prevention of complications (Watters & Moran, 2006; Rockwell, 2010).

Many older patients and their informal carers encounter **problems in the transition** from hospital to home since it is a complicated, challenging process (Mistiaen & Poot, 2008; Popejoy, 2008). Besides the high rate of morbidity associated with hip fracture in the older population, there is also the fact that patients are frequently transferred between hospitals and community settings where the patients' health is put at risk due to problems with communication (Allen, Ottmann & Roberts, 2013; Toscan *et al.*, 2013). Hospital discharge in older patients was defined as a vulnerable transitional stage in the patient care pathway (Foss & Askautrud, 2010; Waring, Bishop & Marshall, 2016). Therefore, successful transition is important for older patients with a fractured femur as preventable readmissions are causing financial burdens for hospitals (Tomura *et al.*, 2011; Popejoy *et al.*, 2012) and may lead to prolonged hospitalisation (Halm *et al.*, 2003; Pearson *et al.*, 2004; Mistiaen, Francke & Poot, 2007).

1.7 The researcher's involvement in an orthopaedic setting

The researcher's career as an orthopaedic nurse commenced in the orthopaedic theatres. In her current role as charge nurse of an orthopaedic ward, she is responsible for older hip fracture patients when they are at their most vulnerable, especially prior to surgery. Through her experience in the theatres and on the wards, the researcher has observed that the problems linked with older fractured femur patients locally are similar to those outlined in the literature and are generally the following; longer rehabilitation process, shortage of beds causing other patients requiring immediate care to wait longer, prolonged waiting time before being transferred to the rehabilitation hospital. These problems delay them from regaining their independence, hence delaying their discharge, with some becoming institutionalised (Smektala *et al.*, 2008).

1.8 Research problem

Fractures of the femur are common amongst frail, older individuals and often cause serious complications on function, mobility and mortality (Price, Sear & Venn,

2009; Marks, 2011; McWilliam-Ross, 2011; Hu *et al.*, 2012; Vu, Day & Finch, 2012; Wales *et al.*, 2012; Sweitzer *et al.*, 2013). An ageing population, a decrease in birth rates and an increase in life expectancy is causing more demands on healthcare systems.

The European Hospital and Healthcare Federation (EHFF, 2012) asserts that two challenges exist in healthcare systems namely; the financial and organisational perspectives. Whilst the financial perspectives include increase in healthcare costs and inactive population, decrease in health funds and an increase in expenditure, the organisational perspectives include challenges which increase the demand for institutions and a reduction in in/formal carers (EHFF, 2012). It is a well-recognised fact that the existing long process of regaining pre-fracture status and independence following a traumatic hip fracture in older patients is also causing problems to the local healthcare system in Malta. In the researcher's experience and supported by relevant literature, factors contributing to this problem locally are the following:

- Increase in the incidence of traumatic falls yielding an increase in older persons admitted to hospital with a fractured femur (HAA Malta, 2016).
- Whilst waiting for long-term care, older patients are occupying a bed at the acute hospital causing a bed crisis resulting in the slowing down of the whole hospital system. Local literature shows that in 2015 there were 140 patients at the acute hospital who did not require acute care when compared with the past years when it rarely surpassed the 60 patients (Malta Today, 2015).
- The lack of expected discharge date to return home or the rehabilitation hospital is dependent upon bed availability at the rehabilitation hospital or the consultant decision.

- The Maltese patients' and relatives' expectations of a period of rehabilitation is causing a reluctance to be discharged home even when they have fully regained their pre-fracture status.
- There are no formal guidelines on patient care pathway or formal discharge planning for older fractured femur patients. It is interesting to note that this problem was also identified in the 2011 in the acute hospital audit conducted by the Johns Hopkins University, U.S. which gave priority to the discharge planning process.

These complex issues inspired the researcher to question existing nursing practice and she felt that it was her responsibility as a nurse “to work towards securing and maintaining working environments that contribute towards the attainment of high quality nursing care” (Maltese Code of Ethics for Nurses & Midwives, 1997, p.3).

1.8.1 Setting the scene for the dissertation

The fact that delayed discharges causes such issues with bed shortages at the acute hospital, made the researcher reflect upon the reasons for lack of continuity of care and support after discharge. She was determined to investigate this issue further and consequently, various meetings were organised with relevant stakeholders, namely hospital management, the Chairperson of the Orthopaedic Department, the Director of Community Services, as well as with the Chief Executive Officer of the acute hospital.

An increase in the incidence of hip fractures, together with time pressures on healthcare resources and societal changes including the loss of traditional carers has contributed towards conducting this study in order to enhance the care pathway of fractured femur patients. When, in the preparation, implementation and evaluation of research studies, the researcher realised that no studies had, to date, been carried out which involved older Maltese hip fracture patients, their family caregivers and HCPs on their journey from admission until discharge, she was motivated to embark on this research study. This, coupled with her experience in the field, contributed towards her recognising the need for this study. It is within this perspective that this study has been undertaken and hence, the overall aim of this study is to enhance the

older fractured femur patient's journey to recovery from admission to hospital and subsequently in the community.

1.9 Structure of the dissertation

Whilst an overview of the study objectives is presented in **Chapter 1**, an extensive literature search conducted from various databases available at the University of South Wales library, using various key words is to be found in **Chapter 2**. This includes a review of the relevant literature which focuses on the journey of the older fractured femur patient from admission until discharge. Any research gaps identified by the researcher are also highlighted.

A theoretical framework is presented in **Chapter 3**, along with an explanation of the selection for this theoretical framework as opposed to other theories. The Habermas (1984) Theory of Communicative Action and the Theory of Systems Lifeworld was used as a guide in this participatory action research. The research methodology is explained in **Chapter 4** whereby rigour is addressed during this participatory action research cycle. The identification of the problem, its relative solutions, modification of the action and its implementation in collaboration with HCPs, patients and their informal carers are considered in **Chapter 5**; the methods. The findings are presented in **Chapter 6** followed by a discussion in **Chapter 7**. Finally, a summary of the strengths and limitations of this research is presented in **Chapter 8**, as well as an overview of what the researcher believes this study has contributed towards the body of knowledge in nursing. Recommendations of how the journey of fractured femur patients may be enhanced are also given in this last chapter.

1.10 Conclusion

This study was designed to allow the researcher to work in collaboration with all stakeholders and together work towards the enhancement of the care pathway of the older fractured femur patient. This research study proposal was acknowledged by the Maltese Government and the researcher received a scholarship grant to conduct this study at PhD level. These reflective thoughts and circumstances demonstrated the importance of conducting this research study locally so as to enhance the level of care older persons with fractured femurs receive from the local acute hospital.

CHAPTER 2

LITERATURE REVIEW

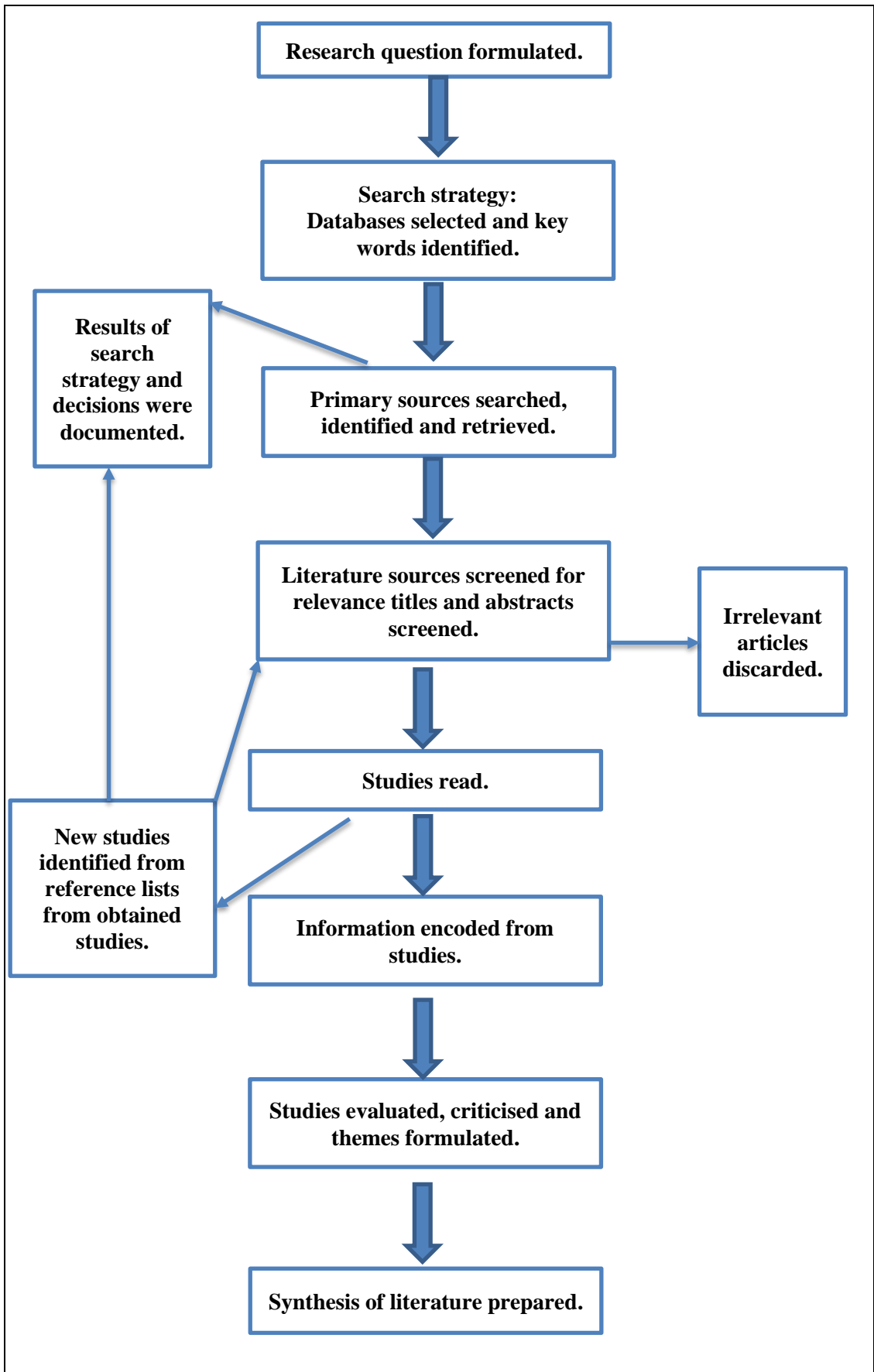
2.1 Introduction

The purpose of this chapter is to explore, discuss, analyse and identify gaps in the existing literature in relation to the journey of older fractured femur patients from the point of admission into hospital until discharge into the community. Factors that may influence the patient's discharge planning are identified and discussed whilst a synthesis of relevant literature outlines the process of the patients' rehabilitation and discharge from hospital into the community. Finally, a concise summary of the evidence is presented, highlighting any research gaps identified by the author.

Hip fractures involve a break in the stability of the femur and can happen anywhere and to anyone especially in older adults. Various literature exists on this subject and literature dating back to 1937 describes that fracture neck of femur was widely discussed and was viewed by an American surgeon Kellogg Speed in 1935 as 'the unsolved fracture' since it was problematic to treat in that era (Johansson, 1937; Brittain, 1938). Most of the studies available on the care pathway of older patients with fractured femur are from across the world and mainly from European countries, U.S.A, Australia and China.

This study's literature review provides focused evidence on older fractured femur patients as opposed to answering an intervention or a specific clinical question (Section 4.1.1). This review was guided by a sequence of tasks adopted by Polit and Beck (2017) which helped the researcher to conduct the literature review in a comprehensive and rigorous way (Figure 2.1).

Figure 2.1 Flow of tasks in the literature review



Source Adapted from Polit & Beck, 2017

2.2 Eligibility criteria formation

The formulated criteria should reflect the research question so that study selection becomes very transparent and any reader would be able to examine why a study was included or not in the review (Hamer & Collinson, 2005). Therefore, a set of eligibility criteria was devised for the selection of studies relevant to this literature review.

- **The inclusion criteria:**

- Studies including the care pathway of an older fractured femur patient from admission to discharge into the community.
- Participants included hospitalised older fractured femur patients over the age of 65, informal carers (ICs) and Health Care Professionals (HCPs) corresponding with the dissertation's recruited population.
- Studies including the older hip fracture patients' and ICs' perceptions.
- Published and unpublished studies or papers exploring the concept and definition of the care pathway and the discharge process of a patient with hip fracture. This ensures that the obtained studies are related to the study variables.
- Research studies published in the English language and conducted in different regions of the world.
- Studies relevant to the title, methodology, research aim and objectives. No limitations were included with regards to the research design.

- **The exclusion criteria:**

- Removal of result titles that were specifically unrelated to the purpose of this literature review.
- Publications on patients admitted and discharged for a short period of time at the emergency department.
- Studies investigating patients undergoing elective orthopaedic surgery, such as hip or knee arthroplasty.
- Studies on discharge planning, including other medical or surgical conditions, such as participants suffering from congestive heart failure, stroke, asthma. Children and adults undergoing surgical day case procedures were also excluded.

2.3 Search strategy for the identification of studies

A three step approach was applied to identify primary sources. Each stage is described below and it corresponds with the flow of tasks presented by Polit and Beck (2017).

2.3.1 Key words used for the literature search process

It is important to select the correct key words when conducting a literature search (Straus *et al.*, 2005; Rebar *et al.*, 2011) so that time is spent appropriately and relevant literature is selected. The main key terms used during this literature search were ‘hip fracture,’ ‘older patients,’ ‘informal carer,’ ‘multidisciplinary teamwork,’ ‘care pathways,’ ‘communication,’ ‘rehabilitation,’ ‘discharge planning’ as well as ‘decision making.’ These key terms were linked together using the Boolean logic operators ‘AND’ and ‘OR’ using various keywords.

Whilst the main key words in this literature search have been outlined in the first column of Table 2.1, other interchangeable search terms (second column) that were used in the literature were identified and used.

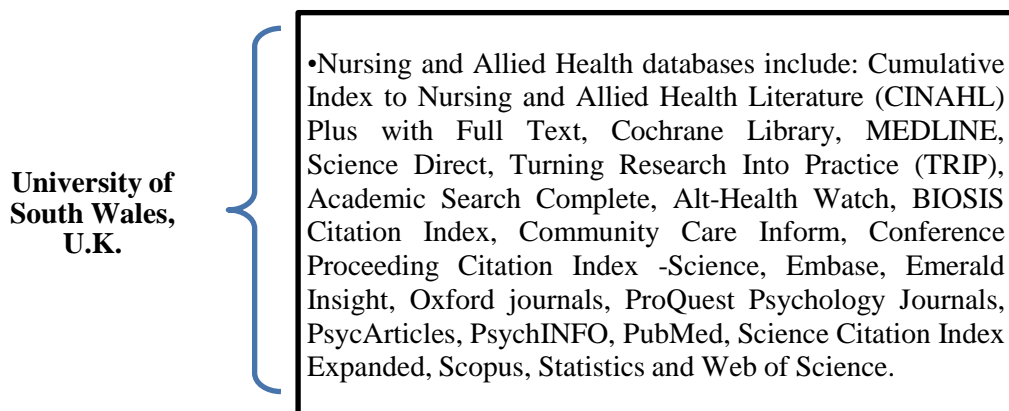
Table 2.1 Key words used interchangeably during this review

Words	Interchangeable words
Multidisciplinary teamwork	Interdisciplinary care, interprofessional, multidisciplinary collaboration, multidisciplinary cooperation, team meetings, transdisciplinary.
Discharge planning	After care, care transitions, transitional care, hospital discharge, continuity of care, care coordination and post discharge follow-up.
Case Conference	Multidisciplinary team conference, geriatric case conference.
Care pathways	Integrated care pathways, clinical care pathways, orthogeriatric collaboration.

2.3.2 Electronic searches

In-depth literature searches were conducted from 2012 and concluded three months before the submission of the dissertation. Documentation of the key words used were kept to avoid unnecessary duplication of the search. This helped to assess various other options whilst ensuring that the search can be repeated (Polit & Beck, 2017). The search was conducted mainly from electronic databases accessible from the library of the University of South Wales, U.K. using various key words (Figure 2.2).

Figure 2.2 Literature search databases



The first electronic search to be conducted was a combined search on the University of South Wales U.K server ‘FIND it’ including the library catalogue and article search. This permitted one literature search to be conducted at ‘one go’ in multiple databases. However, this literature search with various keywords (Table 2.2) yielded a large amount of literature (n=28,944). Applying the same keywords with the limiters activated by date from 2002 onwards provided a total of 15,699 articles.

Table 2.2 Search strategy results from the FIND it database

Database Search	Keywords / MeSH terms	Limits / Filters	Total no.	
<p>‘FIND it’ including: library catalogue & article search.</p> <p>Provides literature varying from books, electronic and peer-reviewed journals, thesis, conference proceedings and newspaper articles (University of South Wales, U.K library website 2017).</p>	<i>Older patient AND Hip fracture</i>	<p>Search without limiters.¹</p> <p>Limits activated Creation date from: 2002 onwards. To obtain recent research studies.²</p>	13,990	8,247
	<i>Older patient OR ICs AND Hip fracture</i>		101	95
	<i>Discharge Planning AND Older Patients AND Hip Fracture</i>		1,156	682
	<i>Multidisciplinary team AND Older patients AND Hip Fracture</i>		1,014	670
	<i>Older patient AND Hip fracture AND care pathways</i>		436	279
	<i>Older patient AND Hip fracture AND Rehabilitation</i>		5,057	1,380
	<i>Older patient AND Hip fracture AND Communication</i>		2,322	1,311
	<i>Older patient AND Hip fracture AND Perceptions</i>		1,185	639
	<i>Older patient AND Hip fracture AND decision making</i>		2,699	1,598
	<i>Older patient AND Hip fracture AND “case conference”</i>		984	798
	TOTALS		Total 28,944	Total 15,699

¹ The fourth column represents the search without limiters.

² The fifth column represents the search with limiters.

Due to the large amount of literature, it was decided to search literature on the Core useful databases or search engines using filters. A detailed description on the Core databases searched, key words used is presented in Table 2.3 and Table 2.4.

Table 2.3 Search strategy results from Core useful databases

Core useful databases			
Database Search	Keywords / MeSH terms	Limits/ Filters	Total no.
CINAHL plus with full text An English language database which provides more than 3 million articles from 1982 to date. (Melnik & Fineout-Overholt, 2011).	<i>Older Patients AND Hip Fracture AND Hospital Discharge</i>	Boolean / Phrase, Related words within full text and articles, English Language, All geographic subset	8
	<i>Older Patients AND Hip Fracture AND Multidisciplinary Approach</i>		3
	<i>Older Patients AND Hip Fracture AND Communication</i>		1
	<i>Older Patients AND Hip Fracture AND Care Pathways</i>		1
	<i>Older Patients AND Hip Fracture AND Rehabilitation.</i>		9
	<i>Older Patients AND Hip Fracture AND Decision making</i>		13
	<i>Older Patients AND Hip Fracture AND Perceptions</i>		26
	TOTAL		61
Cochrane Library	<i>Older Patients AND Hip Fracture</i>	Limits activated. Creation date from: 2002 onwards.	15
	<i>Older Patients AND Hip Fracture AND Discharge Planning</i>		1
	TOTAL		16

Additional searches were carried out using other Core useful databases. This database search is further outlined in Table 2.4.

Table 2.4 Search strategy results from additional Core useful databases

Database Search	Keywords / MeSH terms	Limits/ Filters	Total no.
<p>MEDLINE</p> <p>World’s largest searchable source, updated daily and covers a wide range of medical literature including research, practice and healthcare services from 70 countries. (Melnyk & Fineout-Overholt, 2011) (University of South Wales, 2017)</p>	<i>Hip Fractures in the Elderly AND Discharge Planning</i>	Limits activated Creation date from: 2002 onwards.	7
	<i>Hip Fractures in the Elderly AND Multidisciplinary Approach</i>		15
	<i>Hip Fractures in the Elderly AND Care Pathways</i>		7
	<i>Hip Fractures in the Elderly AND Decision Making</i>		1
	<i>Hip Fractures in the Elderly AND Perceptions</i>		28
	TOTAL		58
<p>Science Direct</p> <p>Elsevier’s leading platform of peer-reviewed scholarly literature articles offering over 3,800 journals. (Science Direct website)</p>	<i>Hip Fractures in the Elderly AND Discharge Planning</i>	Filter activated: Publication title, Year, Topic & Content type	17
	<i>Hip Fractures in the Elderly AND Multidisciplinary Teamwork</i>		8
	<i>Hip Fractures in the Elderly AND Care Pathways</i>		12
	<i>Hip Fractures in the Elderly AND Decision Making</i>		45
	<i>Hip Fractures in the Elderly AND Perceptions</i>		6
	TOTAL		88
<p>TRIP</p> <p>A clinical search tool which permits health specialists to access the highest quality clinical data research for practice. (University of South Wales, U.K library website, 2017)</p>	<i>Hip Fractures in the Elderly AND Perceptions AND Discharge Planning”</i>	Database provides articles from 2000 onwards	210
	<i>Hip Fractures in the Elderly AND Multidisciplinary Teamwork</i>		0
	<i>Hip Fractures in the Elderly AND Interdisciplinary Approach</i>		76
	<i>Hip Fractures in the Elderly AND Care Pathways”</i>		66
	<i>Hip Fractures in the Elderly AND Decision Making</i>		3
	<i>Hip Fractures in the Elderly AND Perceptions</i>		169
	TOTAL		524

2.3.3 Searching other resources

Another search for literature was conducted by reviewing reference lists of research articles already in hand and deemed relevant to the study with the aim of identifying potential studies (n=16) not previously retrieved in the electronic search. Another source for literature search was the library of the Faculty of Health Sciences, University of Malta for studies conducted locally. This resulted in three dissertations.

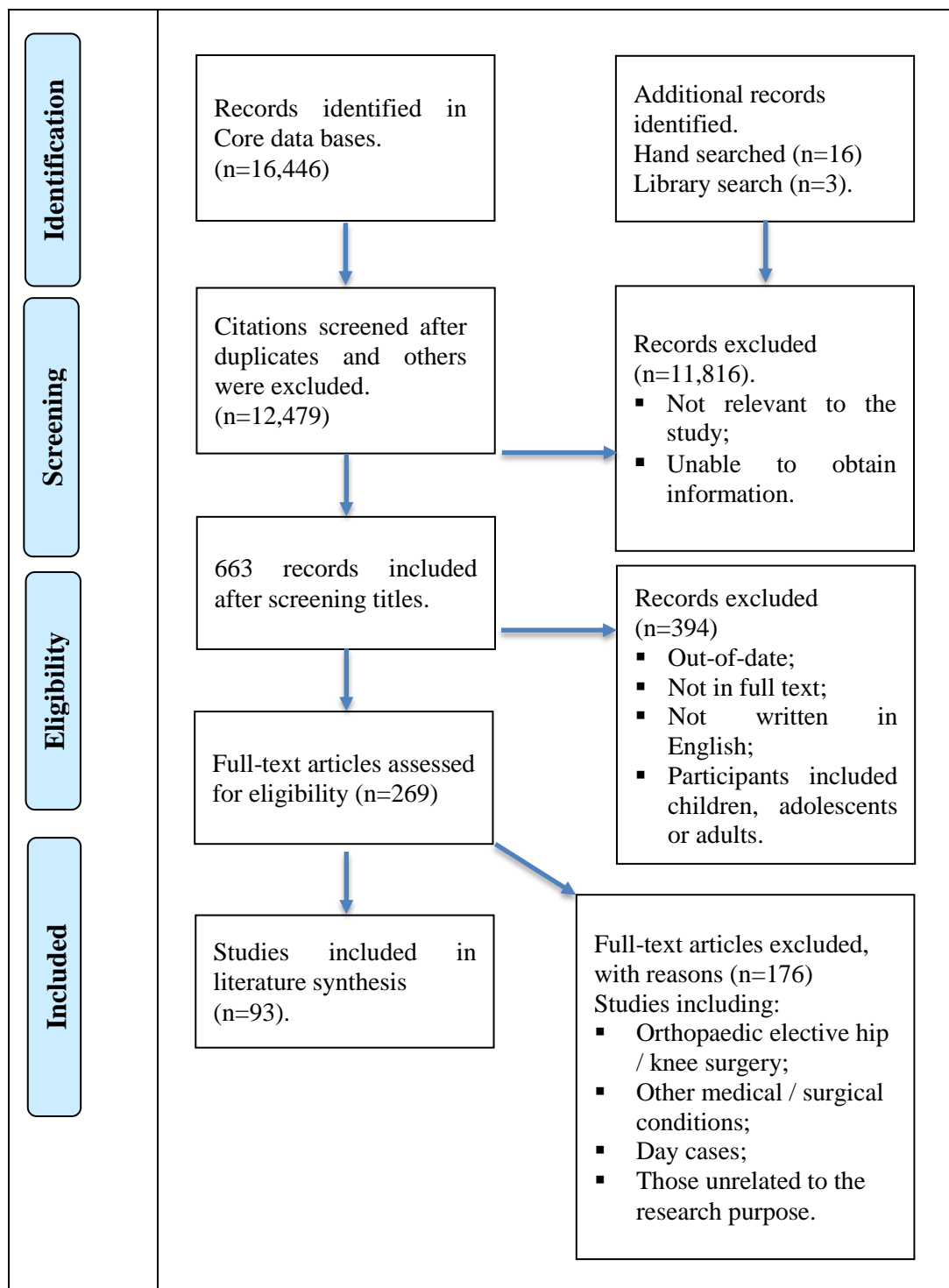
2.3.4 Results and screening of literature sources

Rebar *et al.* (2011) state that a literature review that reveals the state of the science should include studies cited within three to five years from the date of study or publication. However, any studies which were not within this date range specification but met the study aim were also considered. Primary sources of data published recently were always utilised, whereas seminal work was not excluded. Studies conducted before 2012 by authors recognised for their scholarly contribution to the subject and who ranked highly in the hierarchy of evidence were included.

In instances of unclear research titles, the abstract was read so that it offered an indication as to whether these studies should be included or not. The selected studies were organised by saving them into designated document folders with indicative titles so that articles could be easily found. Those articles which were deemed to be of a high quality, of relevance to the study and within the eligibility criteria were retained for further analysis. After the exclusion of duplicate articles, those not written in the English language, commentaries, abstracts, irrelevant documents as well as those which were not actually found, the final search yielded a total of 663 articles. The next step was to screen the remaining articles (saved studies) by reading titles and abstracts. The resulting total amounted to 269 articles which were then appraised in greater detail. Based on full-text articles, a total of 93 articles were included. The **selected studies** were from various countries including European countries, Norway, the U.S.A., Australia, as well as from some Asian countries.

A detailed description on the databases searched and key words used was given in Tables 2.2, 2.3 and 2.4 and studies retrieved (n=16,446) is presented in Figure 2.3.

Figure 2.3 Prisma flow diagram³

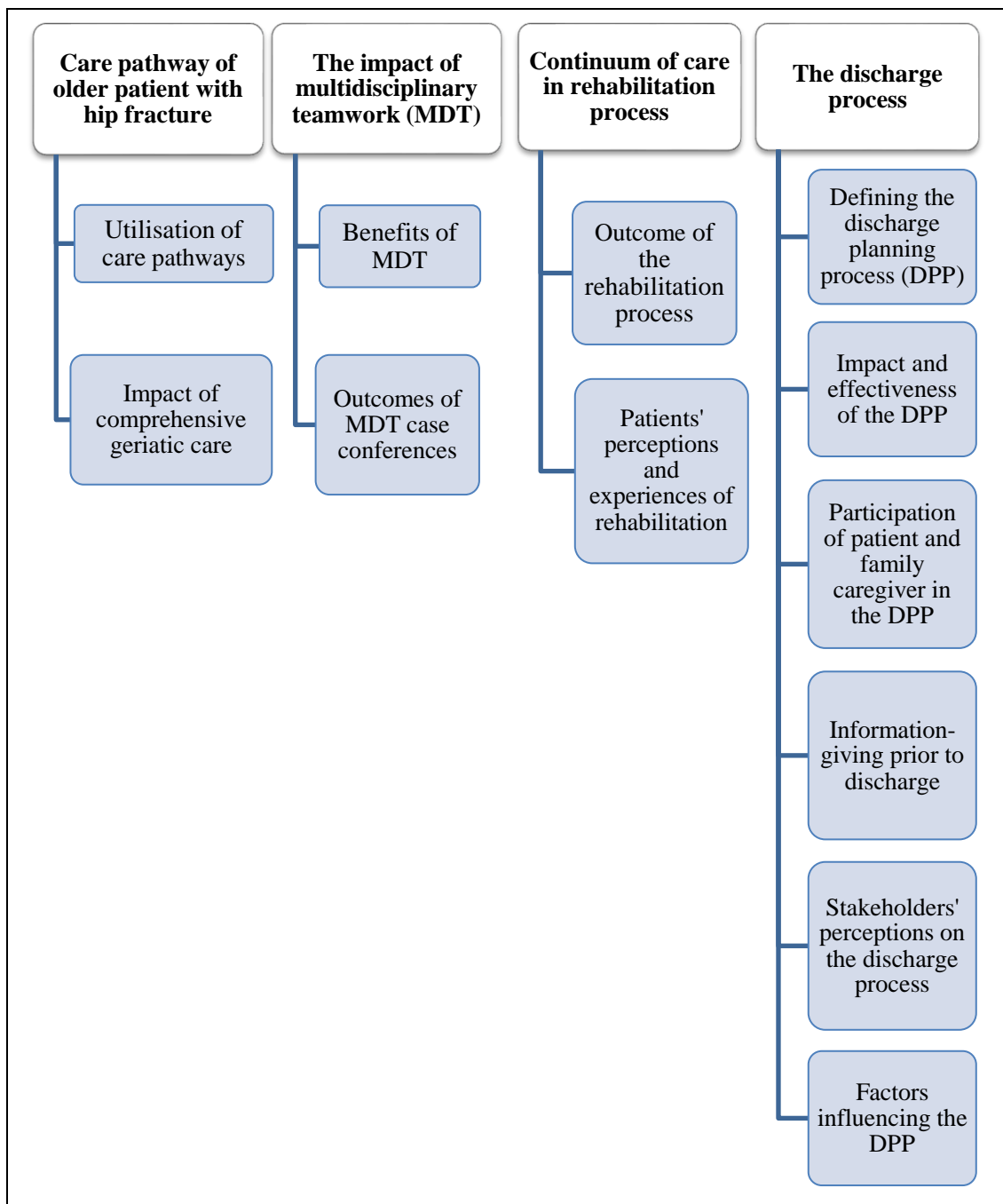


³ Downloaded from: <http://prisma-statement.org/PRISMAStatement/FlowDiagram.aspx>

2.4 Formulation of themes and synthesis of literature

The themes emerged by conducting a thematic analysis guided by a set of questions adapted from Polit and Beck (2017). These thematic possibilities were established based upon five types of themes namely: “substantive, theoretical, generalisability or transferability, historical and researcher” (Polit & Beck, 2017, p.17) (Appendix 2). Four themes were formulated resulting from the thematic evidence found in this thorough literature review (Figure 2.4).

Figure 2.4 Themes formulated from the literature review



2.4.1 Care pathway of older patients with hip fracture

This section scrutinises the compiled research studies which address the clinical care pathway of a patient with a hip fracture from admission until discharge within the community. The above themes that emerged from this review will be critically analysed and discussed below.

2.4.1.1 Utilisation of care pathway

Researchers throughout the years defined integrated care pathways as planned multidisciplinary care which provides a thorough care strategy and which guide the phases of the care plan for a specific group of patients (Atwal & Caldwell, 2002; Olsson *et al.*, 2009; Rotter *et al.*, 2010). Many countries have launched their protocols or guidelines for care pathways in patients with a fractured femur to achieve optimal care and standardisation of care (Sakai *et al.*, 2015). To mention a few there are the Scottish Intercollegiate Guidelines Network (SIGN, 2009), guidelines by the Association of Anaesthetists of Great Britain and Ireland (2011), as well as by the British NICE guidelines (2011).

Several studies have focused mainly on the use of care pathways in older hip fracture patients revealing improved recovery, improved patient outcomes (Teo & Mador, 2012), prevented complications (Pickles *et al.*, 2014), decreased mortality rate (Burgers *et al.*, 2014) and reduced hospital length of stay (Koval *et al.*, 2004; Olsson *et al.*, 2007). However, there is a lack of high-level evidence about the notion that care pathways promote teamwork, even though it is often stated that it promotes teamwork (Xyrichis & Ream, 2008; Deneckere *et al.*, 2012).

A retrospective before-and-after study by Burgers *et al.* (2014) presents encouraging results because they found that older patients with a fractured femur had a decrease in hospital length of stay from nine to six days ($p < 0.001$). Although they did not find any statistical significance in readmission rates ($p = 0.720$) and no significance ($p = 0.698$) for 30-day mortality, they claimed that clinical pathways improve the quality of care (Burgers *et al.*, 2014). This study helped in the implementation of the clinical pathway which eventually improved the quality of patient care. However, Polit and Beck (2017) claim that a problem with retrospective designs is that recall is usually less accurate than concurrent measurement.

Similarly, the findings of a Systematic Review (SR) conducted by Rotter *et al.* (2010) which included twenty seven studies and involved 11,398 participants, found that integrated care pathways decreased hospital complications (OR 0.58, 95% CI 0.37 to 0.94) and enhanced documentation (OR 11.95, 95% CI 4.72 to 30.30). Additionally, the authors reported that there were no differences in readmission rates or in hospital mortality whilst the only difference found was a decrease in length of stay and a decrease in hospital costs. Substantial heterogeneity had prevented the authors from conducting a meta-analysis on the decrease in length of hospital stay and costs (Rotter *et al.*, 2010). However, findings in the above SRs can be highly considered because SRs are at the top of the hierarchy of evidence and represent the strongest evidence which comes from careful synthesis of numerous Randomised Controlled Trials (RCTs) (Polit & Beck, 2017).

An additional benefit on the implementation of clinical pathways in patients with fractured femur found that older patients experienced less time to surgery when compared with the control group (less than 24 hours, $p=0.001$), venous thrombosis risk assessment and prophylaxis were improved ($p=0.004$) and patients were discharged home on treatment for osteoporosis ($p=0.008$) (Pickles *et al.*, 2014). As specified by these authors themselves, this retrospective medical record audit was limited due to the small sample size and single centre. Thus, one must not exclude that these findings need to be analysed with caution. Conversely, these findings revealed that the use of care pathways in the care of older patients with hip fracture had improved patient care.

Further findings were reported following the implementation of a geriatric hip clinical pathway in Hong Kong where the preoperative length of stay was decreased by 4.5 days from 6.1 days to 1.5 days (Lau, Fan & Leung, 2013). The inpatient mortality rate revealed a decrease from 2.7% to 1.25% after 4 years, together with a decrease of more than 50% in the length of stay in the rehabilitation hospital (Lau, Fan & Leung, 2013). Further benefits were that 80% of the patients in the study were able to be discharged to their previous destination. Although the study was conducted over a span of four years, it illustrated that the use of clinical pathways were very effective.

In a much cited cost effectiveness analysis study implementing an integrated care pathway, Olsson *et al.* (2009) found a 40% decrease in costs per patient with a fractured femur when compared with usual care and noted that 75% of the patients in the intervention group were successfully rehabilitated when compared to 55% in the comparison group. Therefore, the implementation of integrated care pathways in patients with fractured femur may enhance rehabilitation outcomes. Moreover, in a quasi-experimental study design evaluating nurses' contribution whilst making use of integrated care pathways, it was revealed that 21% of the patients regained their pre-fracture status in the activities of daily living when compared to 5% in the comparison group (Olsson, Karlsson & Ekman, 2007). This is consistent with the findings of Chamberlain and Pugh (2015). They found that the introduction of care pathways, together with the provision of a care pathway admission booklet were utilised on admission in 90% of the older fractured femur patients and resulted in a higher adherence with national standards.

An additional research paper by Tseng *et al.* (2016) identified different health-related quality of life trajectories and assessed two care models consisting of comprehensive care (n=91) and interdisciplinary care (n=97), compared to usual care (n=93) in hip fracture patients. The difference between the groups was that the comprehensive care had interdisciplinary care, management for nutrition and depression, fall prevention programme and 12 months' rehabilitation whilst the interdisciplinary care incorporated a geriatric consultation, discharge planning and four months of rehabilitation at home. It also showed that participants in comprehensive care (p=0.049) and interdisciplinary care (p=0.012) had better physical and mental health and improved recovery when compared to the usual care (Tseng *et al.*, 2016). Although the findings of this RCT are only relevant to older fractured femur patients, they indicate that both programmes can be applied in practice.

The data supported the approach that integrated care pathways enhance continuity of care and provide better-quality patient care whilst decreasing fragmentation (Jansen *et al.*, 2006; Stein & Rieder, 2009; Wilhelmson *et al.*, 2011). Connor and Kissen (2010) pointed out that, integrated care pathways offer the best opportunity for providing individualised and dignified care whilst renewing professional relations. There appears to be good evidence on the benefits of care pathways which enhance

the quality of care of older patients with a fractured femur. To further assist these older patients to regain their pre-fracture health status, various hospitals have introduced comprehensive geriatric care (Appendix 3).

2.4.1.2 Impact of comprehensive geriatric care on patient outcomes

The involvement of geriatric care and integrated care pathways are repeatedly used and studied in the literature implying diverse results, especially in cost-effectiveness and hospital length of stay (Olsson *et al.*, 2009; Buurman *et al.*, 2010; Rotter *et al.*, 2010; Lynch, Shaban & Massey, 2015). However, when it comes to patients' benefits, there is strong and consistent evidence that geriatric involvement with the elderly patients admitted with hip fractures has shown an increase in functional level, decrease in mortality, decrease in the risk for long term care and thus increases the possibility for the patients to return to their home (Friedman *et al.*, 2008; Ellis *et al.*, 2011; Kristensen *et al.*, 2016; Stenquist *et al.*, 2016).

In an experimental study conducted in Northern Taiwan by Shyu *et al.* (2010a) using an intervention programme (geriatric consultations, rehabilitation programme and discharge planning) the authors found an improvement in health outcomes in older patients with a hip fracture. Findings revealed that in the intervention group, there was statistical significance in the overall health outcomes; in pain ($p=0.002$), in mental health ($p=0.004$) and vitality together with physical function ($p<0.001$) during the first year following discharge (Shyu *et al.*, 2010a). The use of an experimental research design helped to yield strong evidence on the intervention programme. Following the same participants so as to explore the effects of interdisciplinary intervention over a period of two years, Shyu *et al.* (2010b) found that patients with hip fractures in the intervention group had better ratios of hip flexion ($p<0.001$), performed better in activities of daily living ($p<0.001$), better walking ability ($p<0.001$), less falls ($p=0.03$) and fewer depressive symptoms ($p=0.005$). The study was a single blinded design in which staff delivering and assessing outcomes were not blinded. The researchers compensated for this by allocating various research duties to different staff in order to decrease bias.

Similar benefits of geriatric care were evaluated by Kristensen *et al.* (2016) in a population-based cohort study conducted in Denmark and which explored whether

geriatric care enhances clinical outcomes in hip fracture patients (n=11,461). It showed that patients under orthogeriatric care had achieved five out of six process performance measures when compared to usual orthopaedic care. Also, patients in the orthogeriatric unit received: more pain relief (1.13 times, 95% CI 1.10-1.16), mobility assessments and treatment for osteoporosis (1.04 times, 95% CI 1.02-1.06), avoidance of future falls (1.15 CI 95% 1.12-1.18) and evaluation of activities of daily living, whilst immediate postoperative mobilisation within 24 hours was similar in both groups.

Further studies evaluating the effectiveness of geriatric care for older patients admitted to hospital, as opposed to usual care, were studied in a SR by Ellis *et al.* (2011). These authors reported a statistically significant difference in patients up to six months (p=0.0002) and up to a year (p=0.003) whereby they were more likely to be back in their own homes when compared to usual care. Other advantages were that in the intervention group (geriatric care), fewer patients were institutionalised (P<0.0001), were less likely to experience deterioration or death (P<0.001) and had improved cognitive function (P<0.02).

These results were confirmed by Shyu *et al.* (2013) when exploring the effects of an interdisciplinary intervention (geriatric consultation, rehabilitation programme and discharge planning) on cognitive outcomes of older patients (n=160) following a fractured femur. It was reported that participants in the intervention group had 75% less possibility (OR=0.25, p=<0.001) of being cognitively impaired after six months following discharge as opposed to those receiving usual care (Shyu *et al.*, 2013). The benefits of geriatric input are consistent with the findings of another RCT conducted by Shyu *et al.* (2016) investigating the long-term effects of a comprehensive care model (geriatric consultation, continuous rehabilitation and discharge planning) on patients with cognitive impairment on admission. A statistical significance in the Activities of Daily Living (ADL) (p<0.05) when compared with the usual care group was reported (Shyu *et al.*, 2016). As discussed in the limitations of the study by the authors, the study generalisability may be limited by the fact that dementia and delirium were not defined and that the study was only conducted in one hospital. However, these studies revealed the need to study older patients with hip fractures

admitted with cognitive impairment which might have developed whilst being hospitalised.

More findings in relation to the benefits of geriatric involvement were investigated in a retrospective case analysis in Australia by Lynch, Shaban and Massey (2015). Results revealed a decrease of 1.65 hours in waiting time at the emergency department together with a decrease in hospital length of stay, which was lowered from 8.74 days in 2011, down even further to 5.9 days in 2013 (Lynch, Shaban & Massey, 2015). These findings were similar to Friedman *et al.* (2008) where an average length of stay of 4.6 days was compared with an expected rate of 5.2 days together with 19.4% lower readmission rates than was expected in the U.S when a co-managed programme was utilised.

A Danish interventional study, investigating the implementation of multidisciplinary geriatric care on patient outcome with a sample of older hip fracture patients (n=495) found a decrease from 15 to 13 days in hospital length of stay (Gregersen *et al.*, 2012). Further benefits resulting from the orthogeriatric intervention group were that the discharge destination was unchanged and the risk of new fractures occurring within two years decreased from 9.5% to 7.7% whilst there was no significance in mortality rate and readmissions (Gregersen *et al.*, 2012). These findings shed light on how the multidisciplinary team works with the geriatricians for the benefit of the older fractured femur patient. Research on these benefits has also highlighted the importance of teamwork amongst healthcare professionals.

2.4.2 The impact of multidisciplinary teamwork

New standards in healthcare delivery in the workplace environment focus on teamwork, cooperation and interprofessional care (Shaw, Walker & Hogue, 2008) where team members work towards a common patient goal (Baxter & Markle-Reid, 2009). In the literature however, the word ‘multidisciplinary’ is used interchangeably with other words, such as, ‘interdisciplinary’ (Popejoy *et al.*, 2012) or ‘interprofessional’ approach (Workman & Pickard, 2008; Baxter & Markle-Reid, 2009; Rout *et al.*, 2010; Puckeridge, Terblanche & Massey, 2017). A key aspect in the delivery of high quality healthcare management of patients with hip fractures is

collaborative teamwork (Tierney & Vallis, 1999; Tarazona-Santabalbina *et al.*, 2012; Lynch, Shaban & Massey, 2015).

Various organisations have emphasized the importance of multidisciplinary teamwork. In the U.K., the NHS plan revealed that old habitual ways of working were giving way to multidisciplinary teamwork and found that teamwork and flexibility had halved the orthopaedic patient's length of stay and decreased institutionalisation (Department of Health, UK, 2000). Similarly, in the U.S., the importance of multidisciplinary teamwork and formation of team training has led to better patient care (Institute of Medicine, 2001). The Maltese Code of Ethics for Nurses and Midwives (1997) states that nurses and midwives should collaborate with each other and with other members of the multidisciplinary team for the optimal delivery of care. A multidisciplinary approach was defined by Liem *et al.* (2013) as a highly engaged team which works collaboratively to decrease the number and seriousness of complications. In a concept analysis, teamwork was defined by Xyrichis and Ream (2008) as:

A dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration and shared decision-making. This, in turn, generates value-added patient, organisational and staff outcomes (Xyrichis & Ream, 2008, p.232).

2.4.2.1 Benefits of multidisciplinary teamwork

Research demonstrates various benefits on the health outcomes of the older patient with a hip fracture when a multidisciplinary approach has been implemented in their care pathway (Stenvall *et al.*, 2007; Shyu *et al.*, 2010b; Rostagno *et al.*, 2013; Hickman *et al.*, 2015). In a SR (n=7 RCTs) with the aim of examining the multidisciplinary approach for older patients in the acute setting, Hickman *et al.* (2015) found that modifying treatment, together with clear communication strategies, can decrease readmission, mortality and functional deterioration in the older population. These findings were analysed by using narrative analysis due to heterogeneity of the study populations, various multidisciplinary interventions and different outcome measures (Hickman *et al.*, 2015). However, researchers clearly

defined the intervention whilst the studies selected were obtained by two reviewers and checked by a third reviewer. These measures helped to strengthen the rigour of this SR.

These results were also confirmed in an Australian study conducting a quality improvement initiative by Puckeridge, Terblanche and Massey (2017) following the introduction of a multidisciplinary approach together with geriatricians who coordinated care from admission until discharge. These authors found a decrease in hospital stay from 10.4% to 8.6% in a year. An improvement in discharge destination to previous residence had increased from 45% to 54% following a hip fracture and complications were reduced from 69% to 66%. The researchers acknowledged that this study presented an important contribution in understanding orthogeriatric care and multidisciplinary contribution, recognising that this is often under reported in the literature. The study also showed that a quality improvement project may affect patient care (Puckeridge, Terblanche & Massey, 2017).

There appears to be good evidence that older fractured femur patients have benefitted from postoperative multidisciplinary care and teamwork (Shyu *et al.*, 2010b). This is consistent with the findings by a RCT (n=199) conducted in Sweden aiming to examine short and long-term outcomes of a multidisciplinary rehabilitation programme in older fractured femur patients (Stenvall *et al.*, 2007). It was found that 84% of the hip fracture patients in the intervention group were discharged from hospital to their previous home environment, whilst only 76% in the control group were able to reach their previous discharge destination. Further findings in relation to mobility were reported and included 62% in the intervention group, as opposed to 53% in the control group, regained walking ability to a similar level they had prior to the fracture (Stenvall *et al.*, 2007).

In contrast to the above advantages, a SR examining the effects of multidisciplinary rehabilitation in patients with fractured femur comprising thirteen RCTs (n=2498) revealed no statistical difference between the intervention and control group for mortality (RR 0.90, 95% CI 0.76 to 1.07) and on readmission rates in six of the RCTs (RR 0.99, 95% CI 0.82 to 1.19) (Handoll *et al.*, 2009). However, in individual trials it was determined that the intervention group did better in daily activities and

mobility than the control group (Handoll *et al.*, 2009). Therefore, these findings cannot be conclusive even though literature indicates better results when a multidisciplinary approach has been adopted (Handoll *et al.*, 2009; Sletvoldt *et al.*, 2011).

The effects of a multidisciplinary intervention programme were analysed from a different perspective by Portegijs *et al.* (2013) who conducted a RCT of a twelve-month home rehabilitation programme on patients with a fractured femur with the purpose of improving their functional level. At baseline, patients perceived at least one barrier whereas 62% in the intervention group, perceived at least one outdoor barrier. In time, the quantity of perceived barriers on entrance decreased in both groups ($p=0.003$) and for outside barriers there was no statistical significance ($p=0.199$) between the groups and it was concluded that there was no beneficial effect over the standard care in perceived barriers in patients with a hip fracture (Portegijs *et al.*, 2013). Engaging in multidisciplinary collaboration is often a challenge for HCPs who work in the acute care setting because of the hectic and continuously changing environment (Baxter & Markle-Reid, 2009).

The studies that have been obtained for this section of the literature review demonstrated that there was less evidence on the effect of multidisciplinary teamwork and rehabilitation in patients with a hip fracture from a qualitative perspective. There was a lack of studies which included patients and healthcare professionals' perceptions on outcomes and benefits of multidisciplinary care. Since there was a lack of qualitative research, findings which are inconclusive when evaluating the effectiveness of multidisciplinary teamwork or geriatric assessment and there is still not enough knowledge about which specific input, if any, is beneficial to the patients (Sletvold *et al.*, 2011). Moreover, few studies were found on the effect of multidisciplinary teamwork in case conferences.

2.4.2.2 Outcomes of multidisciplinary case conferences

Multidisciplinary team case conferences are comprehended differently and various terms are used interchangeably by HCPs. This is clear from existing literature using various words for the same process; family meetings (Griffith *et al.*, 2004), discharge planning conference (Efrimsson, Sandman & Rasmussen, 2006), case conference

(Bangsbo, Duner & Luden, 2014) and care planning meetings (Donnelly *et al.*, 2013). Most of the data exploring the effects of multidisciplinary case conferences generally dates back to around fourteen years ago.

Discharge planning conferences aim to organise resources and encourage patient involvement in their care in association with relocation (Efrainsson *et al.*, 2004) as well as achieving good quality care in home care environments whilst decreasing readmissions (Efrainsson, Sandman & Rasmussen, 2006). Whilst there is an overall agreement about the importance of case conferences and involvement of patients and their family, the phenomenon of power in case conferences was studied by well-known researchers Efrainsson *et al.* (2003) conducting a case study with an older patient. Findings demonstrated that the content of the discharge planning conference was more oriented towards medical status and administrative issues and the HCPs dominated the conversation, whereas the patient felt powerless and was left with a sense of being considered as an item (Efrainsson *et al.*, 2003). Moreover, the authors concluded that the patient exclaimed that she wanted to participate but at the same time, she felt rejected from participating in the case conference because of the complexity of the situation. Since a purposive sampling method was selected, these findings are limited to the target population.

Taking a purposeful sample of eighty women aged over seventy years, results showed that decisions had already been taken and the participants were expected to be pleased with the decisions whilst healthcare agents often defended their actions upon the excuse of the bureaucratic praxis (Efrainsson *et al.*, 2004). So, it may be argued that both the patients and the hospital staff were ruled by the system.

Another research report by Efrainsson *et al.* (2006) concluded that participants, including patients, relatives and HCPs, had taken various roles during discharge planning conferences. The first role exhibited by subjects was that presented as persons and relatives, and the other called 'outside' view was revealed in their status as patients, next of kin or as HCPs and/or institutional representatives (Efrainsson *et al.*, 2006). The authors concluded that participants ended up in a dilemma due to role conflict which made the discharge planning conference constrained by an institutional framework which hinders the possibility to express personal wishes.

In further studies in relation to multidisciplinary teamwork, Griffith *et al.* (2004) explored the opinions on family meetings of patients in a geriatric rehabilitation hospital between families and HCPs. With regard to case conference meetings, the patients and their family pointed out that these meetings lacked clarity of purpose and they experienced lack of informed consent, whilst HCPs identified three important themes including meeting preparation, staff skills and the aftermath (Griffith *et al.*, 2004). In spite of this, overall findings showed that family meetings were viewed beneficially by patients and their families whilst it was recommended that these meetings required adequate preparation and consent, skilled facilitation whilst promoting independency (Griffith *et al.*, 2004). However, findings should be interpreted carefully because perceptions may vary and participant interest may change over time.

This is congruent with the study by Bangsbo, Duner and Luden (2014) who found that there were four different situations of participation that were considered by the older patients during multidisciplinary case conferences, which are; being an active individual, passive individual, active patient or passive patient. Important contributors towards these positions are; health professionals, family members and the older persons, themselves. Conversely, older patient participation is questioned by the imbalance of power (Efraimsson *et al.*, 2003) and knowledge, together with the pressure for beds and timely discharge (Donnelly *et al.*, 2013).

Donnelly *et al.* (2013) explored the experiences and perceptions from the HCPs' perspective and their findings were grouped into four main communication themes: 'mutuality and information-giving', 'patient-centred care', 'inclusiveness' and 'clear outcomes'. The authors argue that for HCPs, the incentive for organising a care planning meeting is more technical, an indication of organisational matters and because of this, the communication process is more procedural in nature whilst the medical model takes over. This is applicable to the philosophical underpinnings of the Habermas (1984) Theory of Communicative Action and Systems Lifeworld. There appears to be consistent findings over time revealing that case conferences are guided by the dominance of the medical model. This appears to have often not been well accepted by the patients, their family caregivers, as well as HCPs. So far, literature suggests that older patients with a fractured femur require high quality care

throughout the patient hospital stay, together with a well-planned discharge through the use of multidisciplinary case conferences.

2.4.3 Continuum of care in the rehabilitation process

Many healthcare systems, together with the social care departments, are giving priority to the rehabilitation and multidisciplinary approach for older people with hip fractures (Atwal *et al.*, 2006; Shaw, Walker & Hogue, 2008; Winter *et al.*, 2016). The management of a hip fracture patient should aim towards their previous functional status, as soon as possible (Deakin, Wenn & Moran, 2008).

2.4.3.1 Outcome of the rehabilitation process

In a SR by Ward *et al.* (2009), the focus was on the outcome of rehabilitation, whether the older patients were rehabilitated in a nursing home, a hospital environment and in one's own home setting. Unfortunately, the authors of this particular review did not find sufficient literature to be able to compare results between other studies and therefore the analysis remained inconclusive. There were three main reasons why this occurred (Ward *et al.*, 2009) namely:

1. The explanation / specification of the environment was not clear enough.
2. The rehabilitation systems were not described in enough detail.
3. While the components of the environments were explained, the sites were not comparable with the inclusion criteria of the review.

Although the researchers who undertook this SR did not find any evidence to compare rehabilitation places, results were thought to be reliable because two of the review authors had individually assessed data quality, whilst another two review authors independently identified potential papers for inclusion. Moreover, the process for the end selection of RCTs was again very rigorous since four authors had independently examined those studies that met the inclusion criteria and when there was a disagreement, it was resolved through a discussion amongst the four of them (Ward *et al.*, 2009).

Another SR conducted by Crotty *et al.* (2010) included nine RCTs and evaluated the effects of rehabilitation interventions (reorientation measures, intensive physical therapy and cognitive behavioural therapy) with the purpose of improving the biopsychosocial functioning of patients following a hip fracture (n=1400). Findings reported that three trials found no statistical significance in independence, physical function or in quality of life whereas another two trials exploring rehabilitation through nurse-led care found (RR 0.30, 95% CI 0.12 to 0.70) reductions in readmission rates, less death rates and a decrease in the inability to return to independency after three months.

These results are similar to a SR by Griffiths *et al.* (2009) which investigated the effects of a nurse-led inpatient unit in the preparation of patients for discharge as opposed to usual care and which found no statistical difference in mortality. However, discharge to institutions was decreased for the patients rehabilitated by the nurse-led unit (OR 0.44 95% CI 0.22 to 0.89), functional condition increased at discharge (SMD 0.37, 95% CI 0.20 to 0.54) whilst early readmissions were decreased (OR 0.52 95% CI 0.34 to 0.80). Having discussed the findings on the impact of the rehabilitation process, it is worth analysing the literature on how older patients with a hip fracture perceive the rehabilitation process.

2.4.3.2 Patients' perceptions and experiences of rehabilitation

In a longitudinal study conducted by Young and Resnick (2009), which analysed perceptions of older fractured femur patients (n=62) in relation to their functional recovery after one year, it was found that rehabilitation services did facilitate their recovery. The findings show that patients perceived that being motivated, maintaining a positive attitude, engaging in rehabilitation activities, actively participating in the programme and following instructions from professionals were key to success in their rehabilitation (Young & Resnick, 2009). Although this study provides rich data on the perceptions of such patients, it is important to note that participants were selected from one metropolitan area only, thus limiting the study's relevance in a different context and environment.

A much quoted research study which explored patients' views of their health situation and their responsibility in their rehabilitation process was carried out by

Olsson *et al.* (2007). They interviewed hip fracture patients (n=13) in an orthopaedic hospital in Sweden. Responses, which varied widely in their commitment to the rehabilitation process, were categorised into three groups; 'the autonomous' which are the self-caring and requested more information, 'the modest' which includes frail patients requiring more support and information but did not request it and 'the heedless' which are the dependent who were unaware of their responsibility and are not interested in information. Older patients also perceived the rehabilitation process positively but desired more information since they were worried about their ability to walk again (Olsson *et al.*, 2007). This phenomenological study shed light on the differences in patients' views regarding the rehabilitation process which needs to be considered in order to enhance the care pathway of older fractured femur patients.

A phenomenological study which explored patients' (n=15) experiences about their recovery process, found that hip fracture patients felt isolated because of restrictions in activities and with less social contacts, dissatisfied and unhappy with life changes whilst others felt satisfied that their expectations were fulfilled (Ziden, Hansson-Scherman & Wenestam, 2010).

In a similar study by the same researchers, the consequences of a hip fracture as experienced by patients (n=18) were analysed. Participants reported that the fracture had caused changes to their body, to others and to their entire life situation (Ziden, Wenestam & Hansson-Scherman, 2008). Further experiences were related to limited mobility, losing confidence in their body, becoming more dependent on others, feeling confined to their home, feeling old, feeling uncertain about their future, being closer to death, losing interest in life and taking one day at a time. Positive impact included; becoming more grateful, valuing oneself more and other's needs, increasing human contact and being treated in a friendly way by others (Ziden, Wenestam & Hansson-Scherman, 2008).

In these two studies which were conducted by the same researchers, findings consistently revealed that apart from physical problems, hip fracture patients also experience psychosocial problems. Despite the fact that data in this last study was collected after a month, which is a short period of time to recover from a hip fracture and views may change over time, the findings shed light on the real experiences on

how older fractured hip patients experience life. Moreover, to enhance trustworthiness of results, researchers primarily read and analysed each transcript individually and then discussed the findings together until consensus was obtained.

In a survey which was carried out in two hospitals in Japan, Kondo *et al.* (2014) distributed questionnaires (n=434) to older fractured hip patients and their families (response rate of 62%). The participants were asked to describe problems experienced after acute care and the support they felt they needed from the hospital after surgery. Findings using both statistical and qualitative content analysis revealed four categories of difficulties with coping which were grouped as: difficulties with ADLs, reduced social activities, physical problems including pain and anxiety about their recovery.

Further quantitative analysis reported that 21.7% responded that they had experienced difficulties in daily life, 7.1% had not experienced any difficulties and 5.1% were unclear. Overall findings reported by older hip fracture patients were that they wanted continuous rehabilitation at the hospital they had been admitted to.

Conversely, Small *et al.* (2009) found that older patients and family caregivers preferred home-like environment community hospitals rather than general hospitals for their immediate rehabilitation. Evidence revealed that although hip fracture patients recognised that rehabilitation facilitated recovery, some patients feared their capability to return to their pre-functional level. Hence, this highlights the need for effective preparation prior to discharge so that patients are well prepared for their transition from hospital to home.

2.4.4 The discharge process

After having been discussed for many years, discharge planning is still widely accepted internationally as recommended practice in the care of hospitalised patients (Appendix 4). There is a remarkable amount of literature regarding types of clinical settings where discharge planning can be adopted for older fractured femur patients in acute hospitals and rehabilitation centres (Bauer *et al.*, 2009; Taylor *et al.*, 2010b; McLeod, 2011).

Numerous studies on the discharge process have been generated over the years in various countries, some of the leading ones are:

- In the U.K. (Atwal, 2002b; Parker *et al.*, 2002; Pearson *et al.*, 2004; Coffey, 2006; Baumann *et al.*, 2007; Rambani & Okafor, 2008; Shepperd *et al.*, 2010; Mitchell, Gilmour & McLaren, 2012).
- In the U.S. (Bull & Roberts, 2001; Halm *et al.*, 2003; Weiss *et al.*, 2011).
- In the Netherlands (Mistiaen, Francke & Poot, 2007).
- In Australia (Bolch *et al.*, 2005; Bauer *et al.*, 2009; Durocher & Gibson, 2010).
- In Japan (Tomura *et al.*, 2011; Nagata, Tomura & Murashima, 2012).

2.4.4.1 Defining the discharge planning process

A gap in the literature which is frequently highlighted is that there is no single definition and an inconsistency in terms, as well as in the aim and function of discharge planning (Andrews, Manthorpe & Watson, 2004; Holland & Harris, 2007) and about discharge practices and effects (Maramba, Richards & Larrabee, 2004; Holland & Harris, 2007). Holland and Harris (2007) argue that the variations in definitions may inhibit scientific development and high-quality patient care. All this creates inconsistencies which may interfere with the process of hospital discharge planning as a concept. Another inconsistency in definitions encountered by systematic reviewers is how to define discharge preparations and how to classify an intervention throughout the evaluation process (Parker *et al.*, 2002; Shepperd *et al.*, 2013). All these discrepancies may cause limitations in final conclusions. Other gaps exist in the literature such as, diverse meanings in definitions when measuring cost-effectiveness and the tools used to measure outcomes or interventions (Simonet *et al.*, 2008; Handoll *et al.*, 2009; Hutchings, Fox & Chesser, 2011).

The aim of effective discharge planning is to reduce hospital length of stay, avoid readmissions, improve patient outcomes, give patients information about their condition, if necessary, whilst improving the organisation of services following discharge home to provide a seamless transition (Damiani *et al.*, 2009; Wong *et al.*, 2011; Shepperd *et al.*, 2013; Al-Maqbali, 2014; Goncalves-Bradley *et al.*, 2016; Pellett, 2016). Goncalves-Bradley *et al.* (2016) asserts that patients should be discharged from hospital at the right time in their care pathway provided that

adequate notification has been given beforehand. Such definitions on the discharge process bring about questions as to how patients and their informal carers experience or perceive the discharge planning process.

2.4.4.2 Impact and effectiveness of the discharge planning process

A recent SR (Fox *et al.*, 2013), which included nine trials, (n=1736), compared the effectiveness of early discharge planning to usual care in older patients. It found a decrease in the intervention group in hospital readmission rates within one to twelve months (RR=0.78, 95% CI = 0.69- 0.90). Moreover, it was reported that there was no statistical significance found in hospital length of stay, mortality or satisfaction with the intervention. However, these researchers scrutinised four studies using narrative analysis and found that early discharge plans were linked to better quality of life within two weeks following hospital discharge.

In an influential SR (n=35 RCTs) by Parker *et al.* (2002) it was found that when a discharge intervention was introduced, the risk of rehospitalisation was significantly reduced (readmission risk ratio 0.851; 95% CI, 0.760 to 0.953; p=0.005). This result was consistent when the intervention was offered by a distinct professional (readmission risk ratio 0.825; 95% CI, 0.699 to 0.974; p=0.023) when compared to care delivered by a team (readmission risk ratio 0.875; 95% CI, 0.744 to 1.028; p=0.105) (Parker *et al.*, 2002). In a RCT investigating the introduction of a discharge plan in older patients following a fracture of the hip (n=126), it was found that they experienced less days (1.89) in hospital when compared with those who had usual care, whilst their families perceived positively their readiness for discharge (Huang & Liang, 2005). Similar to the above findings, Huang and Liang (2005) found that those patients in the intervention group which had been given a discharge plan had less readmission than participants in the control group with rehospitalisation of four participants in the intervention group versus 13 patients in the control group.

In a much-quoted RCT examining the usefulness of a comprehensive discharge plan and home follow-up for older patients (n=363), Naylor *et al.* (1999) found no significant difference in functional level, in cognition and patient satisfaction. However, a statistical significance was found in the intervention group where older patients were less likely to be readmitted than the control group (20.3% versus

37.1%; $p < 0.001$) and the intervention had less hospital days per patient (1.53 versus 4.09 days, $p < 0.001$) (Naylor *et al.*, 1999). These results were confirmed by the findings of Smith, Fields and Fernandez (2010) who pointed out that, when an older patients' physical therapists' discharge plan was not implemented, they were 2.9 times more likely to be readmitted.

Similar to Parker *et al.* (2002) in their SR, the findings of Shepperd *et al.* (2013) which incorporated twenty-four RCTs including hospitalised patients ($n=8098$) to determine the usefulness of individual discharge plans, found a statistical difference in length of stay (mean difference -0.91, 95% CI -1.55 to -0.27, 10 trials) and readmission rates (RR 0.82, 95% CI 0.73 to 0.92, 12 trials). However, there was no statistical significant difference for mortality rate in elderly patients with a medical problem (RR 0.99, 95% CI 0.78 to 1.25, five trails) or for being discharged home from the acute hospital (RR 1.03, 95% CI 0.93 to 1.14, two trials) (Shepperd *et al.*, 2013). Furthermore, this review had included twenty four RCTs who were reviewed independently by two researchers and had a pre-designed data extraction sheet which had minimised selection bias.

Moreover, the above SR ($n=11,964$) was updated three years after with the purpose of evaluating the effectiveness of individualised discharge plans, as opposed to usual discharge care (Goncalves-Bradley *et al.*, 2016). They found a minimal decrease in the length of stay (mean difference -0.73, 95% CI 1.33-0.12; 12RCTs) in those older patients who had received a personalised discharge plan and a lower readmission rate in the intervention group at three months after discharge (RR 0.87, 95% CI 0.79 to 0.97; 15RCTs) (Goncalves-Bradley *et al.*, 2016). These two SRs were conducted three years apart with four of the authors involved in both reviews; the findings revealed that the impact of individualised discharge plans on hospital length of stay was minimally decreased over the years.

In contrast to the above findings, Lin *et al.* (2009) in an experimental study design found no significant difference with the introduction of the discharge planning in relation to hospital stay ($p=0.696$), whilst a significant difference was found in self-care knowledge ($p=0.001$). Moreover, Lin *et al.* (2009) found a significant difference in the experimental group regarding quality of life including: mental aspects of social

functioning ($p=0.028$), vitality ($p=0.004$), physical pain ($p=0.009$) and general health perceptions ($p=0.029$). This highlights the importance of the development of an agreed comprehensive discharge plan according to patients' needs (Bowles *et al.*, 2008; Lin *et al.*, 2009; Tomura *et al.*, 2011).

The role of the discharge planning nurse has recently been reviewed in a qualitative study. The nurse in this role was found to promote patient and caregiver decision making during the development of the agreed discharge plan (Tomura *et al.*, 2011). Further findings revealed that making a discharge plan required: involvement of the family caregivers and a process which consisted of: developing a plan, accomplishing an agreement, turning the plan into practice and discharging the client (Tomura *et al.*, 2011). It is important to note that family members may have valuable information which may enhance the patient's care plan which will be of great benefit to the patient care pathway (Lindhardt, Nyberg & Hallberg, 2008). Consequently, patient and family caregivers' participation is considered crucial for successful recovery and smooth transition from hospital to discharge back into the community.

2.4.4.3 Participation of patient / family caregiver in discharge process

Literature on the importance of patient and family involvement and engagement in care support has recently proved that it enhances the quality of transitional care, especially in the older population (Efrainsson *et al.*, 2006; Naylor & Keating, 2008; Preyde, Macaulay & Dingwall, 2009; Dyrstad, Laugaland & Storm, 2015). In Dyrstad, Laugaland and Storm (2015) patients were observed on admission ($n=21$) and on the day of discharge ($n=20$) in two hospitals in Norway which included conversations with patients ($n=41$) and family members ($n=28$). Findings in this study revealed that information meetings between professionals and the patients varied in their perspective. Whereas a lack of involvement in decision making was observed and experienced by participants. Findings reported that participation was affected by time limitations, HCPs' work overload, patients' condition as well as preferences when family members were the older patients' advocates and supported the patients in both processes.

Similarly, the findings of a SR with meta-analysis by Rodakowski *et al.* (2017) which included fifteen RCTs found that the involvement of family caregivers in

discharge planning process interventions was related to a decrease in hospital readmission rates by 25% at 90 days and another 24% less readmissions at 180 days. Rodakowski *et al.* (2017) concluded that the involvement of family caregivers in the discharge planning process decreases the risk of rehospitalisation especially in the older patients discharged back into the community. According to a study exploring the collaboration between family members (n=156) of older patients and nurses, it was found that when there was a low level of collaboration, the participants reported low satisfaction (Lindhardt, Nyberg & Hallberg, 2008). Other contributing factors for low satisfaction were due to feelings of self-blame, family members provided care for less than a year, powerlessness and unavailability of psychosocial assistance (Lindhardt, Nyberg & Hallberg, 2008).

Further studies on participation of stakeholders in hospital discharge decisions (older patients n=13, family caregiver n=12 and HCPs n=7) by Popejoy (2011) collected data forty-eight hours prior to expected discharge. Results identified that 54% of the hospitalised older patients' were keen to have collaborative participation (decide with others) and another 31% preferred active participation (decisions were made by self). Findings on family caregivers reported that 50% favoured collaborative participation; another 25% preferred active participation collaboration whereas another 25% of the family members requested passive participation (decisions made by others) in discharge destination decisions. Additionally, HCPs took a passive level of participation and only 15% favoured active participation (Popejoy, 2011). Since the data originated from only one family carer, generalisation of findings should be considered with caution.

Findings in the literature consistently revealed that collaboration and involvement of patients and their relatives is the key to success in patient care from admission until discharge (Lindhardt, Nyberg & Hallberg, 2008; Digby & Bloomer, 2014; Rodakowski *et al.*, 2017). Digby and Bloomer (2014) studied the family caregiver's experience (n=8) when their next of kin was admitted to an inpatient geriatric unit and considered how involved they became in the care decision. It was determined that when their relatives were hospitalised the burden of the experience and participation was continuously there (Digby & Bloomer, 2014). Additionally, the challenges confronted by families were; communicating with HCPs, being requested

to participate in care decisions particularly with the discharge planning process as well as family disagreement (Digby & Bloomer, 2014).

2.4.4.4 Information-giving prior to discharge

Recent research into the identification of the factors for effective discharge planning in older patients in a geriatric hospital revealed that continuous, open and timely communication was fundamental in all stages of discharge planning (Bull & Roberts, 2001; Arora *et al.*, 2010; Kirsebom, Wadensten & Hedstrom, 2013). Communication was important between the multidisciplinary team and community personnel, amongst healthcare providers and patients and between health workers and family members of older patients (Bull & Roberts, 2001).

Whilst there is general agreement about the importance of information-giving on discharge in the older population, various common factors influencing this process were discussed in the literature. In a review, Allen, Ottmann and Roberts (2013) revealed that the exchange of information between systems of care, education and cooperation between all stakeholders improves communication in the discharge process for older patients. On the other hand, lack of dialogue and absence of understanding each other's role are inhibitors to communication. Toscan *et al.* (2013) conducted sixteen interviews to explore multiple care transitions in an elderly patient with a hip fracture whilst involving her family carers and HCPs. Using an ethnographic design, the patient was shown to have experienced various transitions in four different care settings before discharge. Four themes emerged from the analysis which included: missing important conversations, confusion about HCPs' role, not knowing what to expect or what is expected and that health policies impede individualised care. This study reflects the challenges experienced by older patients with a fractured femur whilst obtaining information which may potentially question practice in care transitions.

In an Australian study, Allen *et al.* (2013) conducted focus group interviews to describe the roles of community doctors in the provision of older clients' information. Participants revealed that a key characteristic in their role was communication which minimises consequences for older people, whereas the

importance of exchange of information with other health and social care professionals through telephone conversations, face-to-face meetings and case conferences were found to be crucial in care transitions. Research has consistently demonstrated the need for better communication between hospital and community and the need for detailed information-giving to the patient to assist in effective management at home (Johnson, Sanford & Tyndall, 2008; Allen *et al.*, 2013).

Literature on information-giving methods prior to discharge of an older patient, explains various forms of enhancing patient and family knowledge including the dissemination of information sheets, information booklets and manuals, visual representation, interaction websites and telephone helplines (Mistiaen & Poot, 2008; Choi, 2011; Schmidt, 2013; Langford *et al.*, 2015; Tsui *et al.*, 2015; New, McDougall & Scroggie, 2016). After hospital information sheets were left with the older patients (New, McDougall & Scroggie, 2016) for the advancement in patients' knowledge about their caring team, together with improved patient communication, had significantly increased (from 31% to 75%; $P=0.0001$) and their expected discharge date (from 54% to 86%; $P=0.004$) was clearly reported.

The findings from a narrative review ($n=44$) to evaluate the use of pictographs during discharge instructions for older adults with low-literacy skills, found that pictographs using simple line drawings together with basic text were the most useful and effective tool to enhance discharge education (Choi, 2011). An intervention study focusing on support and education was conducted in Canada (Langford *et al.*, 2015) which included the handing out of a patient-centred educational manual, together with four videos of five telephone coaching calls by a physiotherapist. The control group received usual care and a one-hour educational session using the manual and videos. Although it was a pilot study to enable power calculation for a future RCT to enhance recovery following hip fracture, findings revealed that it was feasible to provide follow-up telephone coaching and concluded that telephone coaching encourages health-promoting behaviours for older clients after a fractured femur (Langford *et al.*, 2015).

A SR exploring the effects of telephone calls by HCPs in the first month following patient discharge, which included thirty-three RCTs ($n=5110$) led to inconclusive

results (Mistiaen & Poot, 2008). It was reported that in twelve studies, the authors found no statistical significance between the telephone follow-up and the control group, whilst the researchers of another twenty-one trials concluded in favour of telephone follow-up calls. Besides these reported findings, other outcomes were shown to make significant differences in relation to telephone follow-ups for: better patient satisfaction, compliance with advice, readmission, anxiety, mood disturbance, pain, self-care deficits, knowledge, visits to the emergency departments and finally, for medication side-effects (Mistian & Poot, 2008).

In a recent evaluation of a new patient educational booklet for the recovery process following a hip fracture, older adults with a history of a previous fall, together with a family caregiver expressed that the manual booklet was comprehensive and satisfactory for their needs but that it should be supported by a verbal explanation by a healthcare professional (Tsui *et al.*, 2015). In today's technological era and computer-oriented society, an unexpected finding was that reported by Schmidt (2013) who found that when informal caregivers were given web-based resources (a website with resources and e-mail access to a rehabilitation nurse) only one informal caregiver communicated via e-mail. Conversely, analysing pre-test and post-test data, it was highlighted that this web-based resource had improved readiness by family members to provide care to the patient.

Reporting on a longitudinal study conducted from the patients' viewpoint to evaluate care requirements amongst a hospital and a primary care centre, it was found that 49.4% of the patients had comprehended the information given to them on discharge very well but after a day following discharge, 30% disclosed that they already had uncertainties about their health status and on how to manage their condition (Suner *et al.*, 2010). As it was expected that over time doubts may increase, the authors found that the occurrence of these uncertainties increased after a week by 46% and by 55% after four weeks. However, it did decrease after a 12 week follow-up with only 44% of participants claiming that they still had concerns.

Various literature has focused on the importance of information-giving to family caregivers to enhance participation in care when patients are discharged (Johnson, Sanford & Tyndall, 2008; Bench, Day & Griffiths, 2011; Tomura *et al.*, 2011;

Weiss, Yakusheva & Bobay, 2011). There appears to be good evidence on the need of information-giving to the patient, prior to discharge.

2.4.4.5 Stakeholders' perceptions on the discharge process

This section provides findings about how the older fractured femur patients and their informal carers perceive hospital discharge. It also synthesizes the findings on HCPs' views on the discharge process. While literature does exist on HCPs' perceptions of discharge processes, there are not many studies which focus on the perspective of hip fracture patients during their transitional process (Efrainsson, Sandman & Rasmussen, 2006; Toscan *et al.*, 2013; Zakzesky *et al.*, 2015).

An important study, which explored **discharge planning from a patients' and informal carers' perspective**, used two hospital discharge readiness scales, a quantitative descriptive approach to examine patients readiness for discharge (n=50) (Brent & Coffey, 2013). Results revealed that the mean of the patients with fractured femur perceptions on readiness for discharge was lower 6.677 (SD 0.123) when compared with patients with medical or surgical conditions 8.1 (SD 1.3). In addition to this, mean scores regarding perceptions of personal readiness including the physical and emotional state was 6.23 (SD 1.20), views considering knowledge were 6.29 (SD 1.04), perceptions of readiness dealing with coping scored 7.01 (SD 0.321) and finally, perceptions on expected support available after discharge were 7.99 (SD 0.279) (Brent & Coffey, 2013). The Readiness for Hospital Discharge Scale tool (Weiss & Piacentine, 2006) was used in this study. Since this was utilised in two other countries and reported a Cronbach alpha of 0.93, it is likely to confirm the reliability of this particular study.

More recent findings from a qualitative study based on twenty seven observations explored older patients' worries about their needs following discharge (Gabrielsson-Jarhult & Nilsen, 2016). It found that the discharge process in itself was considered tiring and necessitated the older patient to adjust from being independent to needing others for care and support. The three themes which emerged were the need for continuous care, achieving a secure life situation and gaining back their independence. Although observation in healthcare settings is an important method of

data collection, findings may be influenced by behaviour distortions (Polit & Beck, 2017), as in this study, older patients were aware that they were being observed.

In a qualitative study exploring the experiences of hospital discharge of older people (n=7) and their families (n=12) in relation to the discharge instructions and management of medications, participants were displeased with the discharge process, especially when it came to delays in discharge and lack of explanation on their medications on discharge (Knight *et al.*, 2011). This caused the older people in this study to experience unnecessary omission of medicines, incorrect dosages, anxiety and confusion whilst a lack of communication existed between the discharging hospital and the community doctor or pharmacist. Rigour was enhanced in this study by the researchers who, apart from collecting data through interviews, also collected patient medication diaries. This mixed methods study had provided data on the impact of information given upon discharge.

Furthermore, these findings are similar to an observational study conducted by Mesteig *et al.* (2010) who found that 59% of older patients reported unwanted incidents after discharge. These incidents were related to medication prescription regime (32%), problems with communication amongst the geriatric management unit and primary healthcare (25%) and those who requested help from primary healthcare due to disagreement between selected services and existing services (17%).

In a qualitative meta-synthesis on the patients' experiences on transitions which analysed fourteen qualitative studies, three main classifications were identified namely: transfer as being unpredictable, frightening and stressful, as part of progress and release and as a "slide into insignificance" (Uhrenfeldt *et al.*, 2013, p.1685). It also showed that patients felt that transitions were critical events where HCPs need to concentrate on patient outcome of transfer as safe, predictable and personal. Further studies were conducted in Norway by Foss and Hofoss (2011) describing older patients' experiences on participation in the discharge planning process by interviewing patients (n=254) using a questionnaire developed purposely for their study. It was found that all older patients expressed a preference for participation, irrespective of their age, which was eighty years plus, whilst there was no correlation between patients' desire for participation and experienced opportunity to be involved

in decisions. These results were further confirmed in that most patients who responded (58%) that they were not involved at all whereas very minimally (56.5%) were allowed to share decisions and when it came to whether they had received information it fell to 42%. Although the questionnaire contained seventy six questions, which seems too long for an elderly person, it had been pilot tested to ensure that the tool was comprehensible and usable.

Two authors Lin and Lu (2005), who are well-known for their scholarly input in discharge planning, conducted a study exploring the burden experienced by family members of older fractured femur patients during the transition phase from hospital to home. The patients and their families (n=98) were interviewed twice, one week after discharge and then again after another month, using questionnaires as a method of data collection with caregivers. The sample consisted of female caregivers (63%), with spouses being the main caregiver in some of the cases. One third of the caregivers took care of other members of the family apart from the frail sick older person. Findings revealed that the family members experienced moderate burdens because of the decline in the elderly person's health. Besides, caregiver burden and functional dependency level of the older person were correlated and another group of carers experienced a greater burden when they were unable to access other resources for help before the fracture and admission to hospital (Lin & Lu, 2005).

These findings are similar to those reported by Shyu *et al.* (2012) on the health outcomes of the informal caregivers of fractured femur patients and the effects of social support on these outcomes. It was found that caring for a patient following a hip fracture over time improves the informal carers' role performance to manage: physical pain, social function and role limitations incorporating emotional and physical difficulties but on the other hand, it had a negative impact to perceived overall physical and mental health of the caregiver.

A phenomenological study was carried out by Pereira and Botelho (2011) with the aim of understanding the lived experiences of family members (n=14) taking the role of informal carers after their relative had an unanticipated hospital event. They found four main themes which emerged: losing control over time, experienced feelings of

loneliness and abandonment, failing expectations caused by discrepancies in daily life and taking control over somebody else's life.

A similar study exploring family caregivers' (n=10) experience with providing care for older patients with a hip fracture for six months following discharge found that the hip fracture was a turning point towards patient frailty, they felt tired, received lack of information about coping and felt frustrated with common issues in healthcare delivery (Nahm *et al.*, 2010). Conversely, it was perceived as an opportunity to dedicate more time to their loved ones (Nahm *et al.*, 2010). Although the sample consisted of females only and was a convenient sample, this study gave an in-depth insight on family caregivers lived experiences.

More findings in relation to older patients' experiences following discharge found that the commonest problems after transition were: issues with follow-up appointments, readmissions, problems with compliance with medications and not being well-prepared for transition (Arora *et al.*, 2010). These findings correspond with the physicians' answers when they were asked about awareness on the patients' admission to hospital, whereby thirty percent maintained their unawareness of patient hospitalisation (Arora *et al.*, 2010). Although patients in various studies (McMurray *et al.*, 2007; Arora *et al.*, 2010; Toscan *et al.*, 2013) perceived a lack of preparation prior to their discharge, it was revealed by Atwal *et al.* (2008) that older patients were not willing to be involved in home visits. They felt that a visit prior to discharge was causing the older patients anxiety, was disheartening and intimidating whilst they were unwilling to abide with the instructions or changes requested by occupational therapists (Atwal *et al.*, 2008).

Studies focusing on **healthcare professionals' perceptions on the discharge planning process** mainly focused on the actual discharge planning process and the impact it had on the patient (Nosbusch, Weiss & Bobay, 2011; Sims-Gould *et al.*, 2015; Waring, Bishop & Marshall, 2016). Older patients are often transferred between different care settings, for example, when an older fractured hip patient is admitted after a fall from a long-term care residence or the postoperative patient is transferred to a rehabilitation centre.

In a phenomenological study, which focused on understanding the experiences of the discharge process amongst various health professionals, findings revealed three themes: basic values, patient resources and framework (Rydeman & Tornkvist, 2006). The thematic framework incorporated factors that influenced the professionals' actions in the discharge process, which were: regulations, resource limitations and written common guidelines made for all the organisations. In this study, basic values were referred to as professionals' values, as they reflected on their own and others' actions of the patients in the discharge process and the patient resources which included cognition, capability to act as well as social support (Rydeman & Tornkvist, 2006).

A study by Atwal *et al.* (2002a), exploring nurses' views of the hospital discharge process utilising a case study approach, found that features of discharge planning were disregarded and neglected whilst discharge needs assessments were not harmonised. Moreover, the lack of communication amongst the multidisciplinary team was regarded as the major barrier that influences the outcome of the discharge planning process (Atwal *et al.*, 2002a). This is consistent with the descriptive study of Kirsebom, Wadensten and Hedstrom (2013) exploring nurses' experiences of organisation and communication within and amongst care settings, including nurses both from the hospital and the community. It was found that further improvement is often required between these care settings due to community nurses perceived problems as to when they should refer the older person back to hospital, whereas hospital nurses pointed out that they often attempted to stop early discharges from hospital (Kirsebom, Wadensten & Hedstrom, 2013).

In a survey questionnaire examining discharge practice and comparing HCPs' perceptions on the discharge process, Connolly *et al.* (2010) found that 85% of the sample (n=455) amongst all HCPs strongly agreed that discharge could be enhanced by improvement in community services. When it comes to disputes in the discharge process, 79% revealed that disagreements happened due to differences in perceptions amongst patients and HCPs, whilst a substantial number of HCPs (64%) agreed that family members attempted to delay the discharge process (Connolly *et al.*, 2010).

Problems between the treating team and patient or family is considered an impeding barrier to successful patient discharge (New, McDougall & Scroggie, 2016).

More findings in relation to HCPs' (n=17) views on what is a safe care transition for older patients with hip fractures was conducted by Sims-Gould *et al.* (2012) in an ethnographic study which found two main characteristics for successful transition, namely: emphasis on the process (communication and collection of information); and focus on outcomes (self-sufficiency and care pathways). Similarly, communication with HCPs was highly valued in the second stage of an action research study with older patients (n=20) but participants were very conscious of the staff time restrictions that continuously inhibited communication (Atwal *et al.*, 2006). Besides, they argued that HCPs were not actively offering rehabilitative services which could enhance healthy ageing (Atwal *et al.*, 2006).

A further similar descriptive survey exploring nurses' discharge planning perceptions, adherence and barriers was conducted via a survey by (n=64) Graham, Gallagher and Bothe (2013) who found that adherence amongst nurses was low (23%) even though they were made aware of the process. Moreover, nurses viewed lack of time and patient factors, including inability to communicate, their general physical condition and the stress caused by the illness as the most common barriers towards effective discharge planning.

Exploring nurses' decision-making in relation to discharge planning, nurses viewed that a discharge nurse coordinator should be consulted when the patient discharge situation did not complement the nurse's expectations (Rhudy, Holland & Bowles, 2010). In addition, nurses viewed unusual situations as disruptive to the nurses' daily work. In another research study exploring physiotherapists' perceptions and decision-making criteria for fractured femur patients after being discharged home from rehabilitation, all participants (n=12) claimed that the performance factor was safety and independence in mobility and it was a key indicator when planning patient discharge, whilst they did not specify length of distance walked to be considered mobile (Taylor *et al.*, 2010b). Furthermore, it was found that when physiotherapists were planning patient discharge after rehabilitation, they placed more importance on individual needs and patient goals rather than on identifying a performance criteria

(Taylor *et al.*, 2010b). Consequently, findings revealed that stakeholders perceived various barriers towards successful discharge planning.

2.4.4.6 Factors influencing the discharge planning process

Discharge planning may be influenced by several factors namely: lack of time affecting teamwork, communication problems with patients and the multidisciplinary team (Watts & Gardner, 2005; Rose & Haugen, 2010; Zakzesky *et al.*, 2015), assessment of patients' needs, and multidisciplinary care (Day, McCarthy & Coffey, 2009). In the literature, there is considerable evidence that the most important components in discharge planning are: communication, education, organisation, patient participation and collaboration between the team (Carroll & Dowling, 2007; Weiss, Yakusheva & Bobay, 2011; Allen, Ottmann & Roberts, 2013).

The Department of Health in the United Kingdom (2010) pointed out that there is shortage of time for assessment because of the continuous pressure to transfer patients and release beds, together with a current trend toward decreasing hospital length of stay. This is consistent with other studies, which reveal that premature discharges were caused by continuous pressures to discharge patients as early as possible due to the inadequate number of hospital beds. This caused shorter hospital stays and insufficient time to holistically assess the patients' needs and organise and plan the support needed for successful discharge (Cotera-Perez-Perez, 2005; Johnson, Sanford & Tyndall, 2008; Wong *et al.*, 2011; Pellett, 2016).

The outcome of pressures on patient turnover and bed use will sometimes cause older patients to be referred to as 'bed blockers' since they cannot be discharged (Coffey, 2006) as there is no appropriate placement for the older patient to go to. This problem is also causing the discharge planning process to be conducted without considering the consequences of such a process. Kim *et al.* (2011) found that the major reasons for delay in hospital discharge were: lack of availability of extended care amenities (28%), patient or family caregiver reasons (15%), postponements of procedures (15%) and test scheduling delays (13%).

A qualitative study was conducted by Waring, Bishop and Marshall (2016) with the intention of identifying threats to safe discharge for older hip fracture patients from

two regional health and social care systems in the U.K. This study included three hospitals and found three types of threats, which in order of importance were: the 'direct' threats suffered by the patient such as falls, sores, medication errors and infection; the 'contributing' factors incorporating patient assessment, patient education, follow-up care, management of equipment and completion of tests; and finally 'latent' factors which included referral appointments, discharge scheduling, limitations on resources, organisational demands and the discharge planning process itself (Waring, Bishop & Marshall, 2016).

A similar exploratory qualitative study by Zakzesky *et al.* (2015) explored, using a convenience sample, how patients (n=14) perceive the discharge process and found that frequent communication with the team, social support, motivation and timelines to get the patient discharged were factors which enhance discharge. Conversely, medical problems, insurance limitations and lack of communication with the medical team were perceived as barriers to successful discharge planning (Zakzesky *et al.*, 2015). Although a convenience sample may not provide the most information-rich sources (Polit & Beck, 2017), participants were consistent in their responses so findings may be considered generalisable to the target population.

Furthermore, a collective case study approach conducted in Australia discovered how stakeholders (n=62) managed to engage patients in communication in relation to the discharge process and five themes were found to be important (Chaboyer *et al.*, 2016). These were: organisational commitment to patient participation, effect of hierarchical culture and professional standards on patient involvement, disregarding health carers' orientations and actions, understanding and discussing patient desires and supporting information-sharing and communication strategies. Although this study included a purposive sample considering patients and their informal caregivers, HCPs, volunteers and patient advocates' perceptions, the findings may be limited by the risk of bias since subjects were selected by organisational contacts.

In an integrated literature review (n=38) on discharge planning which focused on nurses' views and experiences linked to discharge planning, Nosbusch, Weiss and Bobay (2011) found that the most common barriers in discharge planning that nurses encountered during their daily practice were: problems with a lack of effective

communication, integrated systems and insufficient time, continuity in patient care responsibilities, knowledge and role confusion. A later study by Weiss, Yakusheva and Bobay (2011), which investigated nurses' staffing levels on the quality of discharge teaching, found that paying more hours of nursing care for better patient preparation prior to discharge had potentially decreased post-discharge utilisation costs. Further barriers towards effective discharge planning were: poor communication, inadequate information-giving on transfer, lack of education of older patients and their family caregivers, lack of continuity of care services and lack of a single point of reference (Naylor & Keating, 2008).

These findings were similar to the ones found by Okoniewska *et al.* (2015) where HCPs perceived that communication, undefined roles and lack of resources were the most common barriers when discharging patients. Also, opportunities for enhancing the discharge process were better organisation of the team and a need for leadership (Okoniewska *et al.*, 2015). Similarly, in discussions which took place within six focus groups, HCPs (n=41) commented on the lack of consistent discharge planning programmes, the absence of communication and organisation between the multidisciplinary team, pressure on bed availability, shortage of staff, unclear role of professionals, lack of awareness on patients' needs, misconceptions on the process and social factors (Wong *et al.*, 2011). It was also reported that the lack of policy on discharge planning and multidisciplinary approach was the central theme identified by participants (Wong *et al.*, 2011). Although the sample included HCPs, the fact that patients and their family caregivers were not included may have limited the findings. Moreover, these findings are consistent with other studies which referred to other barriers hindering integration of care and where the key factors included conflicting and contrasting agendas between health and local social entities, lack of understanding and threat to established roles (Jarrett *et al.*, 2009).

Literature on factors influencing discharge planning frequently describes barriers to discharge planning from the hospital perspective. However, the social perspective is rarely discussed. Reviewing four hundred and fifty-three case notes conducted in an acute orthopaedic ward of a London hospital, Rambani and Okafor (2008) found that, the patient hospital length of stay is dependent on the family contribution and patient derived factors that were existent prior to admission. They revealed that the

two main issues were not organisational problems but were attributed to 66% social issues and 28% due to postoperative sepsis (Rambani & Okafor, 2008). Moreover, this study was crucial in identifying new data, since the researchers claimed that this study had demonstrated that delays in the discharge process are not always due to organisational factors but it was due to predisposing and vulnerability factors (Rambani & Okafor, 2008).

Nordmark, Zingmark and Lindberg (2016) focused on the involvement of nurses and homecare organisers in the discharge planning process. Their explorative study design included collecting data from written document forms, seminars with staff, as well as a web-based survey. They found that staff had reached an agreement on what the discharge planning process should entail but had not reached an agreement about who and how the process should occur which may indicate why the process had not been standardised in practice. Although mixed results were reported, the triangulation method represents reality in practice in relation to the organisation of the discharge planning process.

An additional research project explored how HCPs experienced the discharge process of elderly patients to primary healthcare with and without an intermediate care hospital. The researcher collected data through one-to-one interviews, observation, document review and focus groups (Dahl *et al.*, 2014). Findings showed that HCPs viewed discharge through intermediate care positively when compared to discharge to primary care and it was perceived more like an extension of hospital rather than an additional part of primary healthcare. This may indicate that when additional resources are available, such as intermediate care, this has a positive impact on HCPs and results in better discharge processes.

Crennan & MacRae (2010) recommend that a comprehensive assessment on discharge will help to prevent readmissions and will increase teamwork and communication between the stakeholders involved in the process. Various authors claimed that communication between the patient and HCPs is the key to effective discharge, since this process denotes the most vulnerable phase in healthcare delivery (Rhudy, Holland & Bowles, 2010; Chan *et al.*, 2013; Okoniewska *et al.*, 2015). However, literature on the barriers to proper discharge planning exist but very

few studies address interventions planned to support HCPs to overcome these difficulties (Nosbusch, Weiss & Bobay, 2011; New, McDougall & Scroggie, 2016). The above studies shed light on the key elements for discharge planning which includes communication, proper and appropriate organisation, education, patient / multidisciplinary teamwork, all key to effective discharge planning (Carroll & Dowling, 2007; Nosbusch, Weiss & Bobay, 2011; Okoniewska *et al.*, 2015).

2.5 Gaps in research

The literature revealed that even though extensive research exists on discharge planning and continuity of care extending over sixty years, gaps in the research highlight the limited scientific evidence on quality indicators (Holland & Harris, 2007). Mistiaen, Francke and Poot (2007) emphasize that there is no explanation on how long and what a post-discharge episode entails. Discharge problems may vary according to various illnesses and the choice of a timeframe is very subjective. It could be argued that problems may occur immediately after discharge and that individual patients' coping strategies and stamina have to be considered too.

An additional gap in the literature on discharge planning on the older patient has mainly focused on transitions from the acute setting to home and very few research findings were available when it comes to transitions from hospital to long-term care homes or rehabilitation centres and vice-versa. Researchers indicate that very few studies exist which describe the HCPs' role in the community when it comes to communication on client information or on the exchange of the information process that is used in practice (Golden *et al.*, 2010; Allen, Ottmann & Roberts, 2013). There appears to be good evidence that an essential component of discharge planning is effective communication, especially communication between hospital and community, however there is a gap in research about the quality of communication (Goncalves-Bradley *et al.*, 2016). These gaps in knowledge in this field of communication in the discharge planning process needs to be addressed further.

Foss and Askautrud (2010) identified that there are gaps in the literature on instruments that can be utilised to observe patients' perceptions on the discharge process and that none of the instruments capture the full range of participation or

deal with aspects of the discharge process identified by the older persons themselves. They continue that the emphasis in the literature is on the information flow from the HCPs to the patient and never the other way round (Foss & Askautrud, 2010). Studies also show that the discharge process in older people has always been related to problems and complications (Bull & Roberts, 2001; Coffey, 2006). According to Weiss and Piacentine (2006) patients' perceptions of discharge readiness is an important outcome but it is rarely studied in clinical or research purposes.

An additional gap was identified by Buurman *et al.* (2010) who highlighted the limited research on comprehensive geriatric assessment and on rigorous follow-up after discharge of an older patient from hospital. The authors pointed out that most of the studies on rehabilitation and geriatric care did not consider physical outcomes (Buurman *et al.*, 2010). There is also insufficient evidence whereby conclusions cannot be drawn on the effectiveness and costs of adopting the multidisciplinary rehabilitation approach in older patients with a hip fracture (Handoll *et al.*, 2009).

There appears to be good evidence that there is a lack of involvement of the older patients and their informal carers' perceptions on the discharge planning process. The above gaps identifies the need for an in-depth study, both in Malta and internationally, which explores hip fracture patients' perceptions as well as those of their family caregivers and healthcare professionals.

It is worth noting that although internationally there is a large body of knowledge of literature on hip fractures, there are no in-depth, large-scale studies or published research on the care pathway in fractured femur patients in Malta. Only a few unpublished research studies could be identified locally on the elderly patients' perceptions and needs following discharge (Micallef Cann, 2011; Azzopardi 2017).

Further gaps in the available literature demonstrate that there are few studies which include patients and their informal carers in the preparation, implementation or evaluation of the research studies in care transitions of older patients who have experienced a hip fracture (Foss & Askautrud, 2010; Rout *et al.*, 2010; Toscan *et al.*, 2013). In Malta, there remains a gap in the literature, since to date, there have been no research studies which have used an action research design in the care pathway of

patients admitted to hospital with a fractured femur. Studying the care pathway of older patients is important as demonstrated in the literature that following surgery, for a fracture of the hip, many older patients suffer deterioration in walking, independency and quality of life, together with psychosocial factors, such as fear of falling, perceived control and coping which are key issues in the rehabilitation process (Olsson, Karlsson & Ekman, 2007; Crotty *et al.*, 2010; Chen *et al.*, 2011; Healee, McCallin & Jones, 2011; Saltvedt *et al.*, 2012).

2.6 Chapter summary and conclusion

This chapter has explored the evidence on various care pathways for older patients who have experienced a hip fracture. Reference has also been made to the discharge planning process which starts from admission until discharge from hospital and subsequently into the community. A thorough literature search was undertaken by following a set of tasks outlined by Polit and Beck (2017). Four main themes emerged from the resulting literature synthesis, namely:

1. The care pathway of older patients with a fractured hip.
2. The impact of multidisciplinary teamwork.
3. The continuum of care in the rehabilitation process.
4. The discharge process.

As has been illustrated above and with reference to the first theme, various studies exist on the use of **care pathways** in older patients who have experienced a hip fracture. Key findings reveal that integrated care pathways have a positive impact on patient outcomes which have included: improved recovery, better patient outcomes, prevented complications, a decrease in hospital length of stay and in fragmentation of care and it proved to enhance documentation. Diverse results on the use of care pathways were only found in readmission and mortality rates.

Research studies on the outcomes of geriatric involvement consisted mainly from SRs and RCTs. The involvement of geriatricians in the care pathway of older patients showed consistent positive results amongst research studies conducted in developed countries. The impact of geriatric comprehensive care found that it

increased functional level, improved overall health, decreased institutionalisation and mortality rates, improvement in cognitive function, better treatment for osteoporosis and hence, a decrease in falls.

The second theme, **multidisciplinary teamwork**, focuses on multidisciplinary teamwork and case conferences. The literature shows that the benefits of multidisciplinary teamwork varied from positive outcomes, such as improvement in discharge destination, decrease in hospital length of stay, older patients' recuperated walking abilities. However, no significant differences were found in mortality and readmission rates. It was found that multidisciplinary teamwork was challenging for HCPs working in the acute setting since it is continuously changing and very busy. The importance of multidisciplinary case conferences was found to be controlled more by the medical model, the technical and the procedural system of the hospital rather than by the patients, family caregivers and HCPs perspective.

The **continuum of care** in the rehabilitation process on the older patients who had experienced a fractured femur and the hospital reported mixed results. Some studies found: a decrease in readmission rates, institutionalisation rates, inability to return to independency, mortality and an increase in functional condition after discharge. Other researchers reported that the rehabilitation intervention did not have any benefits when measuring independence, physical function, quality of life and mortality. Moreover, research on the stakeholders' perceptions showed that the rehabilitation process had enhanced the recovery process, maintained a positive attitude and motivated patients. Others perceived that they were anxious about coping in the rehabilitation process due to limited mobility, pain, social isolation, dependency on others and loss of self-confidence.

The last theme was the **discharge process** where findings demonstrate the importance of communication during this transitional process.

Key findings reported were the following:

- There is an inconsistency in terms of defining discharge planning.

- The impact of individualised discharge plan, as opposed to usual care, revealed inconsistent results in hospital length of stay and readmission rates.
- Patient and family caregiver participation improves the quality of transitional care, lessened the length of stay in hospital and decreased readmission rates.
- Good evidence exists on the need of information-giving to the patient and family caregiver prior to discharge and various influencing factors such as continuous, open and timely communication were discussed.
- The discharge process was perceived by patients as complex and tiring, not planned according to the individual patients' informational needs. They also experienced unwanted incidents, especially with medication regimes and perceived problems with communication amongst geriatric management and primary healthcare. Family caregivers perceived the transition process as unpredictable, frightening and stressful whilst HCPs perceived the importance of communication as important.
- Key findings on factors influencing the discharge planning process were mainly: lack of time, communication problems, multidisciplinary teamwork and collaboration, patient education, shortage of hospital beds, unclear role of HCPs, lack of recognition of patient needs, involvement in decision-making process and lack of community support.

In summary, five gaps in research were identified which highlight the need for this in-depth study. These gaps include:

1. There is a need for more studies on the quality of communication during the discharge planning process.

2. Lack of studies including patients, informal carers and HCPs in the preparation, implementation and evaluation of research studies on the journey of older patients with hip fracture from admission until discharge.
3. More research is required about the effectiveness of multidisciplinary teamwork in older patients with a hip fracture.
4. The perspective of service users and their family members on the care pathway and the discharge process has not been studied in Malta. There is a need for in-depth and rich information on the discharge process of older patients with a fractured femur. Literature on discharge planning focused more on qualitative research designs rather than quantitative.
5. There is a consistent increase in the older population and falls resulting in a rise in the number of older patients with hip fracture being admitted to hospital. This is causing an increase in the use of healthcare funds within this area.

Various studies have presented diverse findings with regards to the care pathway of hip fracture patients. No local studies conducted with patients, family caregivers and HCPs associated with this study topic could be identified. In light of the above gaps in the literature and the need for local studies, the aim of this study is to enhance the older fractured femur patient's journey from hospital admission to discharge in the community. The next chapter will present the theoretical framework of how the Habermas (1984) Theory of Communicative Action and the Theory of System and Lifeworld guided this study.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 Introduction

This chapter describes the rationale for the use of the Theory of Communicative Action (TCA) by Habermas (1984) as a theoretical framework to guide, build and support this study. It also gives a brief explanation of the TCA and the Theory of System and Lifeworld ideologies. The purpose of theories is to guide research and practice (Cody, 2006; Rebar *et al.*, 2011; Parahoo, 2014) to make findings more meaningful, to generate new knowledge and to describe relationships amongst phenomena systematically (Polit & Beck, 2017).

The journey of the older patient who has sustained a hip fracture from admission until discharge in the community is complex and challenging. Older patients with a fractured hip and their family caregivers encounter problems during hospitalisation, particularly during the transition from hospital to home. Health Care Professionals (HCPs) also face difficulties with designing robust discharge strategies.

HCPs also defend their dominant and sometimes paternalistic approach by justifying it in the name of patient well-being and safety. This results in the systematic functioning of hospitals as an institution that ‘controls’ patient care. Therefore, for the researcher to better comprehend the hospital as a system which influences the journey of the older patient with a hip fracture, a critical social theory was selected.

The focus of critical theorists is on domination and how some groups in society dominate the lives of others and hence, inhibit those in oppressed groups from reaching their full capabilities (Habermas, 1984; Reason & Bradbury, 2008; Williamson, Bellman & Webster, 2012).

3.2 Selection of the Habermas Theory of Communicative Action

The selection of a correct theory is based upon whether the selected theory has explained, predicted and described concepts of the research problem (Polit & Beck, 2017). Rebar *et al.*, (2011) explain that research problems come from practice and theory and can be regarded as a 'large braid' entwined together to develop knowledge. The action researcher must think carefully and select the theory which best suits the research whilst clearly stating this selection from the beginning and throughout the dissemination phase (Koshy, Koshy & Waterman, 2011). The unique philosophical question asked within a practice discipline such as nursing was discussed by Cody (2006) when questioning what guides nursing practice. He revealed that before the introduction of nursing theories, a list of traditions and rules used to guide practice, whilst nowadays many nursing frameworks include values such as caring, respect for others and focused presence into their conceptualisations (Cody, 2006).

For the purpose of this study, subject-related theories were primarily taken into consideration. There are psychosocial theories of ageing that exist which question practice, such as theories of ageing. However, they do not deal with fundamental issues about the organisation of good quality care (Wadensten, 2006). Psychosocial theories such as the Theory of Selective Optimisation with Compensation (Baltes & Baltes, 1993 in Heinz *et al.*, 2017) are more focused on how older adults can cope with old age by concentrating on achievements and strengths rather than losses (Heinz *et al.*, 2017). Therefore, theories of ageing were excluded since they are based upon the psychosocial aspects of ageing and directed towards successful ageing. These theories of ageing do not consider how older patients should be treated as individuals or how they can be empowered to make choices about their care when they are hospitalised. Consequently, psychosocial theories were eliminated.

Other theories which have been widely used in nursing were also examined, such as Orem's Self-Care Deficit Nursing Theory (1971) and Neuman's Systems Theory [NSM] (1972). Although both theories based their foundations on the importance of looking at the patient as a whole and recognises that he/she is the self-care agent who decides upon one's own care, both theories were eliminated. Orem's model was

excluded because it includes key assumptions which were derived from the medical model. The NSM allows the nurse to be the assessor, analyser and the change agent of the system of concepts he/she uses (Neuman & Fawcett, 2011). Therefore, the rationale for rejecting the NSM was due to the fact that decisions about the patient journey are taken solely by HCPs whilst the Habermas TCA insists on a communicative collaborative approach between the MDT, the patients and family caregivers.

Another nursing theory which was considered was Roy's Adaptation Model. It is composed of four adaptive modes which are physiological, role function, self-concept and interdependence (Roy, 1984 as cited in Brydolf & Segesten, 1994), which continues to be useful over the years for education, research and in practice (Roy, 2011). This model, which is also widely used in nursing research, views the person as a holistic adaptive system which is constantly interacting with the changing environment and in turn, affects the environment (Roy, 1984 as cited by Tolson & McIntosh, 1996). Although Roy's theory could have helped to guide this study by helping older patients to adapt to their illness, this theory does not demonstrate how an older patient should remain autonomous during the decision making process and how to be a more equal partner with HCPs.

An organisational change theory which was developed by the social scientist Kurt Lewin (1951) and which divides the change process into three stages; the "unfreezing, transitioning and refreezing" was also examined (Hellriegel, Jackson & Slocum, 2002). Lewin's model is focused more on the effects of forces that either endorse or hinder change and is highly applicable in radical organisational change, however it does not take into consideration the human emotional state and experiences (Kritsonis, 2005). Lewin is considered to be the founder of modern social psychology who contributed greatly towards the development of action research. However, one critique was that participants were not included in the setting of agendas or in decision-making (Koch & Kralik, 2006). Thus, Lewin's change theory was deemed irrelevant to this study since excluding the stakeholders' feelings and experiences does not correspond with this study's research questions.

Critical realism was developed by the philosopher Roy Bhaskar in 1975 and since this theory is often used by the nursing profession, it was considered by the researcher. Two important distinctions were made by Bhaskar (2008), namely the 'intransitive' and 'transitive' dimensions of knowledge. The philosopher contests that events must occur independently of the experiences in which they are apprehended (Bhaskar, 2008) and one of the distinguishing characteristics of realism is 'cause and effect.' Bhaskar's critical realism was highly criticised because describing human behaviour using these principles rejects the person's autonomy (Dickinson, 1999). Besides, if the critical realist separates events from experience, this theory rejects the concept of holistic care which includes the biopsychosocial, economic and spiritual needs of the older patients with a hip fracture after a fall. Provided with these limitations, this theory seemed not applicable to this study's research questions.

An additional theory which was considered by the researcher was the Theory of Power as Knowing Participation in Change developed by Barrett in 1990 which originated from Rogers' science of unitary human beings. In this theory, Barrett, as cited by Leksell *et al.* (2001), highlighted that power is explained as being conscious of what one is selecting to do, feeling free to do it and doing it intentionally. Succinctly, Barrett (2010) describes that power is the ability to participate knowingly in change. She continues that the theory does not only describe power in an individual but it also relates the understanding of power in groups, regardless of their size, type or purpose. However, this theory was considered to be irrelevant to this study since it does not consider how the patient is being influenced by the hospital as a system. Moreover, it does not discuss how decisions are taken and by whom, whereas Habermas argues that participants should be equal collaborators in the decision making processes and that no one should exert power over the other.

Parsons' Sick Role Theory was started from his understanding of illness as an abnormality. Parsons' theory claims that if many people enter into this sick role there would be a threat to the values of the whole system. Thus, he devised the 'sick role mechanism' explaining how ideally a doctor and a patient could interrelate (Parsons, 1991). He continued that within these mechanisms, patients and doctors had to abide by a number of 'rights' and 'obligations' attributed to their roles. Considering

Parsons' theory, as opposed to Habermas, one might argue that Parsons does not deal with the communicative nature of social interaction and continued to 'treat culture as an objective system part' (Turner, 1991, as cited in Parsons, 1991).

Another theory considered was the Social Cognitive Theory which was developed by Bandura in 1986 and was founded on the concept that people learn by observing others (Bandura, 1989). He explained that human behaviour is influenced by personal, environmental and behavioural influences. Bandura discusses the concept of human agency in this theory and gives a central role to "cognitive, vicarious, self-reflective and self-regulatory processes" (Bandura, 1989, p.1175). He continues to explain that the ability to exercise control over one's own thought processes, motivation and action is a human characteristic. Although this theory allows older patients to take action about their health, it does not deal with how they can be self-care agents in an environment continuously controlled by HCPs.

Following the appraisal of the above theories and models, the most suitable theory considered for this study was the Theory of Communicative Action (TCA) and the Theory of Systems and Lifeworld, both by Habermas (1984). The exploration by Habermas of social life in late modernism demonstrates that no social organisation, including both governmental and civilised groups, can claim to be fully integrated as a whole but instead there are only organisations and groups continuously communicating and disputing with each other (Kemmis as cited in Reason & Bradbury, 2008). This suits the purpose of this participatory action research study, as it will guide the researcher to consider all stakeholders' perceptions whilst involving them to take collective action. Yet, in research, it is not enough to discuss and give a rationale for selecting a theory which guides the study, researchers should also explain how the theory is incorporated in all aspects of the study (Fawcett & Gigliotti, 2001).

A summary comparing the above theories is presented in the table below.

Table 3.1 Comparison of other frameworks besides Habermas' Theory of Communicative Action.

Subject	Theory title	Author/s	Summary of the theory	Rationale for exclusion	Comparison with Habermas' Theory
Subject related theories.	Theory of Selective Optimisation with compensation.	Baltes & Baltes, (1993).	Focused on how older adults can cope with old age by concentrating on achievements and strengths rather than losses.	Does not include how older patients with fractured femur can be empowered to participate in their own care.	
Nursing theories.	Orem's Self-Care Deficit Nursing Theory.	Orem, (1971).	Promotes self-care agency and is based on the concept that individuals have the capability, right and responsibility to care for themselves.	Excluded because it includes key assumptions which were derived from the medical model.	Participants communicate and collaborate together to identify a shared concern and provide a solution.
	Neuman's Systems Theory.	Neuman, (1972).	Oriented towards wellness and wholism.	Allows the HCPs to be the assessor, analyser and the change agent and therefore the HCP will control the patient's hospital stay.	Habermas insists on a communicative collaborative approach between the multidisciplinary team, the patients and family caregivers.
	Roy's Adaptation Model.	Roy, (1984).	Views the person as a holistic adaptive system which is constantly interacting with the changing environment and in turn affects the environment.	Although Roy's theory could have helped to guide this study by helping older patients to adopt to their illness, this theory does not demonstrate how should an older patient be autonomous during the decision making process and how to be an equal partner with HCPs.	Participants are equal collaborators in the decision making processes.

Table 3.1 Comparison of other frameworks besides Habermas' Theory of Communicative Action (cont.)

Subject	Theory title	Author/s	Summary of the theory	Rationale for exclusion	Comparison with Habermas' Theory
Change theories.	Lewin's change theory.	Lewin, (1951).	Focused more on the effects of forces that either endorse or hinder change and is highly applicable in radical organisational change.	Participants were not included in the setting of agendas or in decision-making. Does not take into consideration the human emotional state and experiences.	<p>In communicative action participants are not primarily concerned with their own self-achievements but they synchronise their action plans on the basis of common situation definitions.</p> <p>Habermas focuses on how some groups in society dominate the lives of others and thus inhibit those in oppressed groups from reaching their full capabilities.</p> <p>Habermas argues that participants should be equal collaborators in the decision making processes and no one will exert power over the other.</p>
Philosophical theories.	Critical Realism.	Bhaskar, (1975).	Bhaskar asserts that events must occur independently of the experiences in which they are apprehended.	Rejects the concept of holistic care which includes the biopsychosocial, economic and spiritual needs of the older patients with a fractured hip.	
Power related theories.	Theory of Power as Knowing Participation in Change.	Barrett, (1990).	Power is the ability to participate knowingly in change.	<p>It does not consider how the patient is being influenced by the hospital as a system.</p> <p>Does not discuss how decisions are taken and by whom.</p>	
Social theory.	Parson's sick role theory.	Parson, (1951).	Parsons theory claims that if a lot of people enter into this sick role there would a threat to the values of the whole system thus he devised the 'sick role mechanism' explaining how could ideally a doctor and a patient interrelate (Parsons, 1991).	Parsons does not deal with the communicative nature of social interaction and continued to 'treat culture as an objective system part' (Turner, 1991 as cited in Parsons, 1991).	
	Social Cognitive Theory.	Bandura, (1986).	Human behaviour is influenced by personal, environmental and behavioural influences. Explains that the ability to exercise control over one's own thought processes, motivation and action is a human characteristic.	Although this theory allows the older patients to take action about their health it does not deal with how they can be self-care agents in an environment continuously controlled by HCPs.	

3.2.1 Relation between the Habermas theory and this study

Born in 1929, Jürgen Habermas is recognised as the well-known interdisciplinary theorist who developed the Theory of Communicative Action (TCA), the pragmatic theory of meaning, the notion of social theory and who published several papers on discourse ethics (Anievas, 2005; Finlayson, 2005). TCA is an extension of the critical social theory and was explained as communication which takes place within a setting of common cultural traditions (Ekstrom & Sigurdsson, 2002). Apart from being acknowledged for his contribution in critical theories, Habermas is recognised as the leader of the second generation of the Frankfurt School Theorists and his work is best understood as the result of continuous response to the critical theory of the first group of Frankfurt School Theorists (Browne, 2000; Duchscher, 2000; Fontana, 2004; Nunes, Rego & Nunes, 2016). The Habermas TCA enhanced the development of the nursing profession through self-reflection by questioning the “ideological basis for nursing inquiry, knowledge and theory development and practice” (Browne, 2000, p.51). Moreover, the Habermas TCA was selected over other theories, such as critical realism, because it closes the theory practice gap (Browne, 2000).

In the TCA, Habermas (1984) starts with the concept of communicative action between two or more participants who are able to speak and act and thus create interpersonal relations. The theorist emphasizes that, for the coordination of actions, subjects need to reach an understanding about the action situation and the plans of action; the fundamental concept of interpretation denotes negotiating definitions of the situation which admit consensus (Habermas, 1984). In his book, Habermas explained that the TCA has three interconnected concerns:

... first, a concept of communicative rationality that is sufficiently sceptical in its development but is nevertheless resistant to cognitive-instrumental abridgements of reason; second, a two-level concept of society that connects the ‘lifeworld’ and ‘system’ paradigms in more than a rhetorical fashion; and finally, a theory of modernity that explains the type of social pathologies that are today becoming increasingly visible, by way of the assumption that communicatively structured domains of life are being subordinated to the imperatives of autonomous, formally organised systems of action (Habermas, 1984, p.Xlii).

3.2.2 Application of rationality and validity claims in the TCA

Habermas contends that human actions are initially coordinated by the speech act and when individuals use language to organise their actions, they enter into specific commitments to validate their words or actions (Finlayson, 2005). These commitments were explained by Habermas (1984) as ‘validity claims’ which happen indirectly and can be created by a speaker versus a listener. If a validity claim needs to be made openly, the speaker needs to make a claim, whilst the only option for the listener is to accept, refuse or keep it pending for some time (Habermas, 1984).

In TCA these three validity claims are embedded in the speech act and if the “well-formedness of the symbolic expressions employed” is left aside, an actor who is concerned to understanding must raise three validity claims with his statements (Habermas, 1984, p.99). These validity claims are that; “ the statement made is true, the speech act is right with respect to the existing normative context and the manifest intention of the speaker is meant as it is expressed” (Habermas, 1984, p.99).

One of the fundamental arguments in TCA is that Habermas (1984) distinguishes between types of rationality used in social action which are the communicative action, strategic action or instrumental action. In an instrumental action, the act is oriented towards success when it adheres to technical rules of action (Habermas, 1984).

Strategic action is considered under “the aspect of following rules of rational choice and assessing the efficacy of influencing the decisions of a rational opponent” (Habermas, 1984, p.285). Moreover, it was argued that in strategic action, individuals organise their actions around money, power and success (Baur & Abma, 2011; Ross & Chiasson, 2011).

Habermas (1984) explains that communicative action is whenever the acts of the participants concerned are organised, not through ‘egocentric calculations of success’ but through actions of achieving understanding. These are laid out in Table 3.1 and include both the action and its orientation

Table 3.2 Types of action (Habermas, 1984)

Action Situation \ Action Orientation	Oriented to Success	Oriented to Reaching Understanding
Non-social	Instrumental action	-----
Social	Strategic action	Communicative action

The Habermas theory is pertinent to this study because it can potentially enhance nurses' understanding of the social organisation of their daily practice and whether and in what way their practice might be reorganised (Wells, 1995). The strength in communicative action is that participants are not primarily concerned with their own self-achievements. They follow their individual objectives under the circumstance that they can synchronise their action plans on the basis of common situation definitions, whilst negotiating these definitions is a vital element of the explanatory achievements needed for communicative action (Habermas, 1984). An additional strength of TCA, which also makes it applicable to this research study, is that although the notion of strategic and communicative action are conceptually different, Habermas made an empirical statement that participants do engage in both methods of interactions but that communication must be 'mutually exclusive' (Niemi, 2005). One cannot ignore the invaluable experience and knowledge that HCPs possess regarding patient care although this could be interpreted as exerting power over the patients. Yet, on the other hand, HCPs cannot take over all the patient care and make decisions for their patients. The Habermas (1984) theory argues that HCPs should not intentionally use their knowledge to their advantage and pressurise the patient into any course of action such as when HCPs talk about a patient condition and discharge plans without addressing him or her directly.

The potential benefits of applying the Habermas TCA to this study is the ability to link strategic rationality to describe healthcare systems that reflect how patient care is ruled by the medical model and by top-down management. Hospital administrative power influences the care pathway of the older patient with a hip fracture because of the pressure for beds and the need for timely discharge. Strategic communication can

be linked to the way HCPs manage to cope with the workload since the needs of the ageing population are exceeding the ability to deliver services as HCPs need to abide with the practices and protocols of the hospital. Therefore, the Habermas TCA can help examine how these factors affect communication amongst all stakeholders.

The strength of the Habermas theory on the notion of strategic action questions the HCPs' paternalistic persistence of 'knowing best' or when HCPs control patients to a preferred end-point by influencing the conversation, by using jargon to overpower patients and thus obtain their agreement (Godin *et al.*, 2007). Hence, applying this theory as a framework in guiding this study assists the researcher to think about the involvement of older patients and their informal carers as equal partners with HCPs. A limitation in TCA is that one cannot absolutely rule out the fact that in every social organisation some form of authority exists (Browne, 2000). However, the above argument is grounded on the degree of power exerted on older hip fracture patients and their family caregivers and not on the presence of power in social organisations.

In this study, the researcher recognises that the participation of older hip fracture patients and their family caregivers is challenging due to knowledge inequality and hospital experience. Two sides of the relationship are therefore emphasized. On one side, there is the advantaged HCPs in a knowledgeable position both in mind and body, whilst on the other, there are patients who are restricted by dependency due to their illness, lack of information in understanding procedures and implications of treatment (Hazzard, Harris & Howell, 2013). Even so, Habermas (1984) believes that the notion of communicative rationality, which denotes an unclarified systematic interconnection of universal validity claims, can be clarified only through the theory of argumentation.

3.2.3 Communication and rational discourse (argumentation)

Meaningful sentences that demonstrate subjective experiences can be approved or discarded from the perspective of the truthfulness or sincerity of the presenter's self-presentation (Habermas, 1984). A speaker can demonstrate whether s/he truly meant what was said by being consistent in their actions; that is, insincerity can be shown by discrepancy "between an utterance and the past or future actions internally connected with it" (Habermas, 1984, p.41).

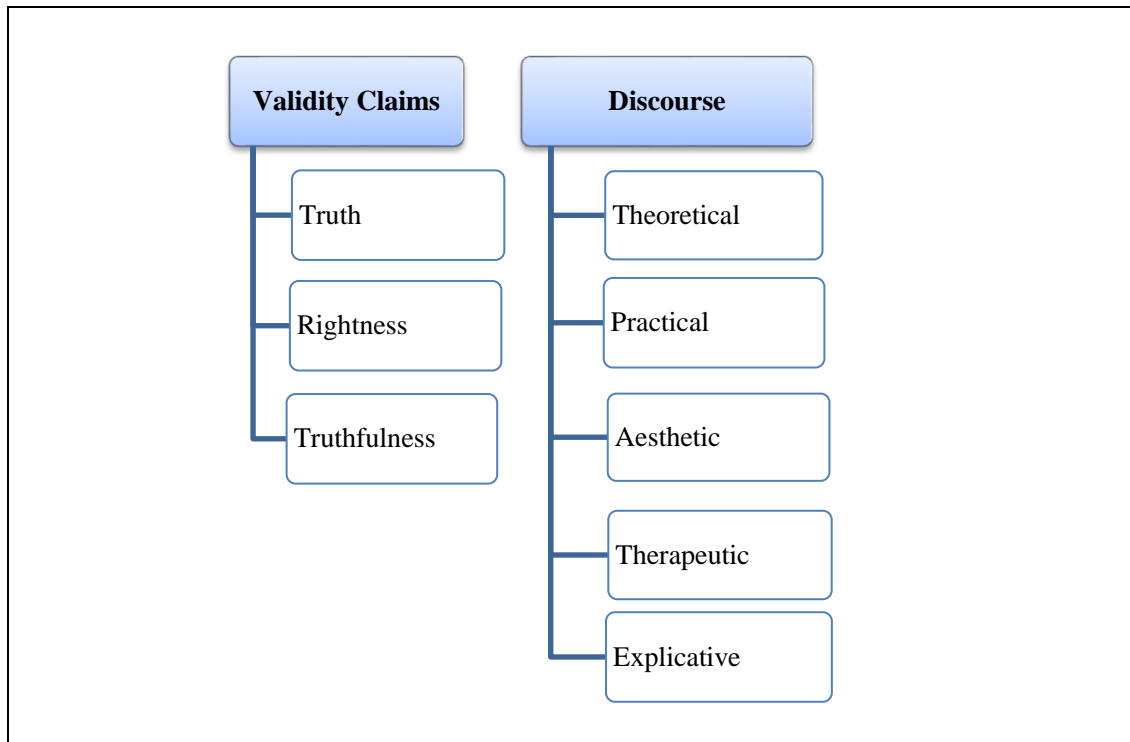
Habermas (2003), as cited by Kemmis in Reason and Bradbury (2008, p.128), presents an updated explanation on his view of communicative action and argumentation where he explains four important presuppositions of argumentation including; “publicity and inclusiveness, equal rights to engage in communication, exclusion of deception and illusion and absence of coercion.”

Another strong point of this theory is that appealing for non-coercion is an important supposition whereby people as independent self-care agents have the right to either be involved or not (Chilton & Cuzzo, 2005). It has been argued that the “ontological foundations of TCA supports a better approach to social existence that is unrestricted from domination, power inequalities and oppression” (Browne, 2000 p.41). This theory makes it more applicable to this research study as older patients are vulnerable especially when their voices are not considered and this increases in older patients with cognitive difficulties and which is considered to be an issue by HCPs (Kirkpatrick, 2003).

The participant behaviour, accuracy of the purpose and the ability to persuade others in a conversation whilst getting them to accept a validity claim, are all strong points in the Habermas (1984) notion of argumentation. This argumentation represents a vital role in the learning processes and a person is considered rational when, in the ‘cognitive-instrumental sphere’, s/he conveys reasonable views and acts efficiently (Habermas, 1984). However, this rationality remains useless if it is not combined with the capacity to learn from mistakes, from the disproof of hypothesis and from the failure of interventions (Habermas, 1984).

Besides the three validity claims (truth, rightness and truthfulness) there are also categories of discourse in the Habermas theory (Habermas, 1984; Finlayson, 2005) (Figure 3.1).

Figure 3.1 **Validity claims and discourse categories**



Source **Adapted from Habermas, 1984**

The appropriateness of this theory is that it assists the researcher and participants to self-reflect on the journey of older patients’ admitted to hospital and examine the emancipatory aspects of TCA. It will help to identify the principles of partnership with patients proposing that older patients should be equal collaborators in the healthcare decision-making processes (Dickinson, 1999; Mohammed, 2006). TCA has challenged nursing practice, because with nurses there is the risk of retaining the status quo, unintentionally supporting patterns of power and forms of oppression endorsed individually and institutionally, whilst declining to challenge dominant beliefs in nursing and healthcare practice (Browne, 2000).

3.2.4 The Theory of System and Lifeworld

The notion of lifeworld was introduced as a necessary complement to the TCA and it is the process of maintaining the objective, the social and the individual world, which is focused in ‘culture, society and personality’ (McCarthy in Habermas, 1984; Baur & Abma, 2011). According to Habermas, lifeworld is recognised through three different mechanisms by which individuals relate with each other and these are; the skill of a person to participate in a shared appreciation of a situation, individuals get

support by being part of a group and the culture whereby a build-up of knowledge has the possibility of agreement to bring about change (Habermas, 1987 in Froggatt *et al.*, 2011). However, a criticism on the Habermas system lifeworld model has been that it lacks a robust analysis of how the lifeworld can defend itself against the system (Baxter, 1987).

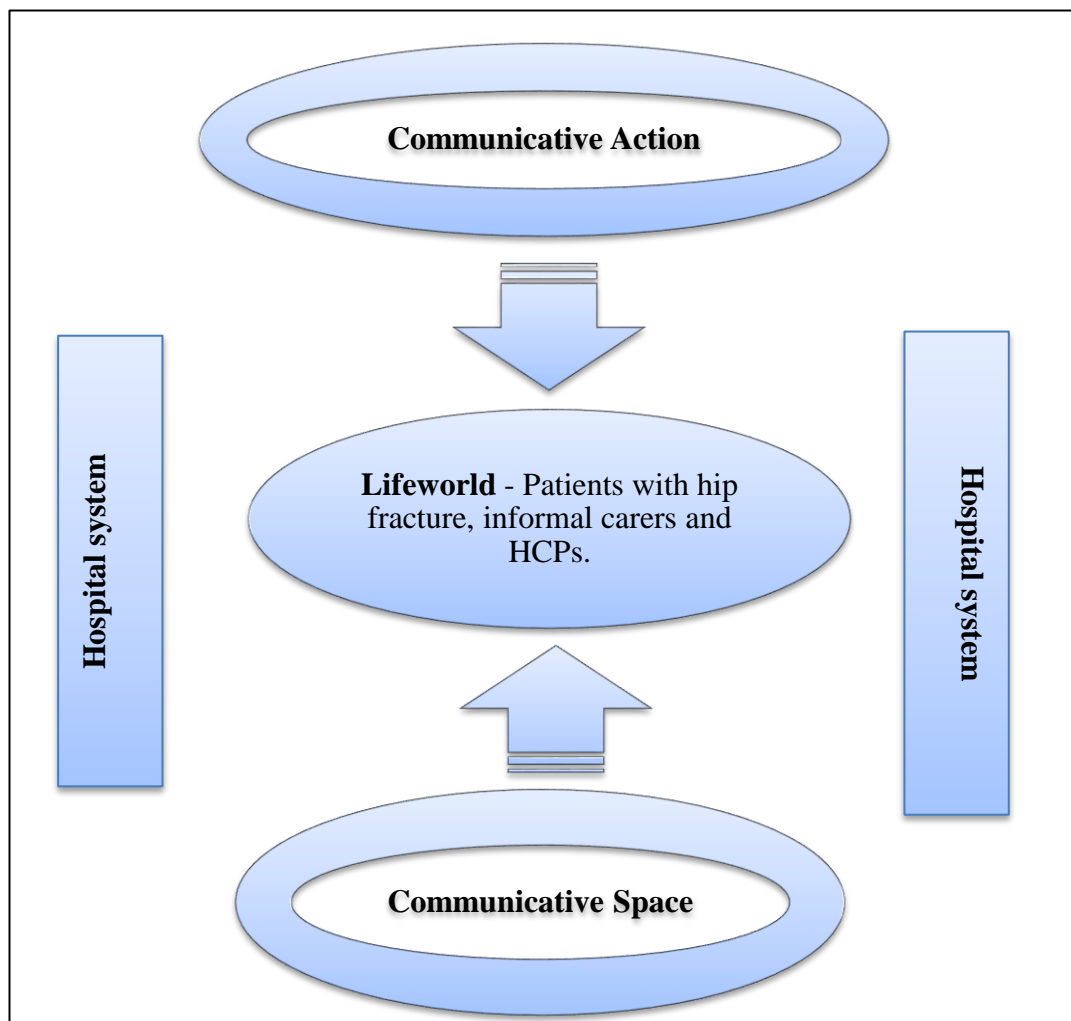
Conversely, the strong point of the Habermas theory on the conflict between lifeworld and system emphasizes how hard it could be for people to engage in complex systems, especially when there is lack of communication as the system has taken over lifeworld (Baur & Abma, 2011). Therefore, when people engage in communicative action they emerge from their strategic and ego-centric rationality, from their official roles and identity with the aim to engage in ways towards attaining mutual understanding (Baur & Abma, 2011). This represents how HCPs practice under the system dominated by the medical model and the hospital administrative power gives priority to the physical aspects in care. The hospital system often abandons the lifeworld of the older persons without considering the psychosocial and spiritual perspective which is an important issue in Malta due to the strong religious belief of the population. This occurs when the care given and the communication style becomes more procedural and ritual rather than communicative and collaborative with older patients.

Furthermore, Kemmis in Reason and Bradbury (2008) discusses the participants' role in participatory action research claiming that, as subjects work together to explore their practices, understanding and situations, speakers 'open communicative spaces' in which they discuss together with a shared commitment to communicative action. Hence, the importance of communicative space is about exchanging information through which change can happen and this can be achieved through a process or mutual recognition of different perspectives (Froggatt *et al.*, 2011; Bevan, 2013).

In this case, the TCA would help to reflect upon practice in relation to the care pathway of patients with a fractured femur focusing on the care pathway and discharge process and communication between patients and the multidisciplinary team. The Habermas TCA and the opening of such a communicative space provides

the opportunity for Maltese older patients who have sustained a hip fracture, their informal carers and healthcare professionals to exchange ideas about how change can occur in practice when it comes to discharge planning. The TCA is applicable to this study since it gives patients and their informal carers a voice to formulate change in practice and thus, it may help address power inequality. Figure 3.2 illustrates the relation between the TCA and this proposed study.

Figure 3.2 The relation between the Habermas theory and this study.



The Habermas social theory as a foundation in nursing research is that it questions and challenges the entire practice. The TCA allows older patients with hip fracture and their family caregivers to be involved in this research study and their involvement is not as subjects participating in a study but as full participants included in the decision-making process about their own care through free open communication.

In this study, the Habermas TCA was applied as a framework to inform the research design so that stakeholders (older fractured femur patients, informal carers and healthcare professionals) can identify the problems in the care pathway from admission until discharge, plan the way forward and implement, as well as evaluate actions. The TCA will also help to inform actions throughout this research process whereby stakeholders participating in this study will have a dual role; that of participants in the research and change agents in practice.

Kemmis in Reason and Bradbury (2008) states that the TCA provides an evaluation of functional reason and it suggests a way out of being stuck in the functional reason characteristic of the administrative systems that govern so much of contemporary life.

3.3 Conclusion

The Theory of System and Lifeworld in relation to communicative action has been discussed demonstrating the enthusiasm Habermas showed towards emancipation, explaining that human actions are coordinated by the use of speech and language and through individuals' organisation of their actions. His theories outline three validity claims namely truth, rightness and truthfulness and which have been discussed together with discourse categories.

The Habermas TCA has also received its share of critique and this has been reviewed, whilst its use in this participatory action research study has been presented. The Habermas TCA explains how it can help individuals to turn from strategic to reflective action, challenging practice based on communicative action (Kemmis in Reason & Bradbury, 2008).

CHAPTER 4

METHODOLOGY

4.1 Introduction

A detailed explanation of the methodology used for this research study is presented in this chapter. This chapter describes the selection process for research as reflected in the literature review. It also analyses which research design was chosen and describes how these designs can be utilised whilst presenting the advantages of selecting one over the other.

4.1.1 Rationale with reference to the literature review

The process of conducting a literature review was compared with a qualitative study by Polit and Beck (2017, p.89) whereby the researcher should take a “flexible approach” to collection of information whilst thinking innovatively about ideas for new sources of data. They comment that the search should continue till “saturation” is attained, namely; when the search strategies produced “redundant information about studies to include” (Polit & Beck, 2017, p.89). Additionally, Rebar *et al.* (2011) discussed the use of Systematic Reviews (SRs) as a resource of evidence-based practice. However, overdependence on them may constrain the variety of problems practitioners consider and the dissemination of important findings obtained through other research methods (Rebar *et al.*, 2011). They continued that even though they are an important source for clinical practice, SRs are not the only resource or evidence for nursing practice. Therefore, this study’s literature review provides focused evidence on older hip fracture patients as opposed to answering an intervention or a specific clinical question.

4.1.2 Rationale with reference to action research

This section outlines the historical perspective of Action Research (AR) and describes how contemporary action researchers have continued to develop other AR

approaches. Various definitions and descriptions of the main characteristics of AR are also given. Finally, the reason for selecting the critical and emancipatory AR, also known as Participatory Action Research (PAR), over other AR approaches is also explained.

4.2 Research design

This section presents the process by which the research design for this study was chosen. It specifies the various considerations that were taken throughout this selection process and why PAR was selected over other research designs. The researcher's philosophical stance was acknowledged since the epistemological and ontological views may influence the research methods used (Koshy, Koshy & Waterman, 2011).

4.2.1 Selecting a research design

The selection of research design has an extended history of debate (Bowling, 2011). Research in nursing has mostly been conducted in two broad paradigms; 'the positivist' and 'the constructivist' (Polit & Beck, 2017). Yet, major critiques of both paradigms were presented by Weaver and Olson (2006) who contended that, apart from being inconsistent with holistic practice, positivism dehumanises people by transforming them into numerical information. The constructivist approach was criticised since it disregards the influence of "biological factors and social structures on the individual action" (Weaver & Olson, 2006, p.464). However, the quantitative and qualitative designs should be viewed as complementary rather than two opposing paradigms (Malterud, 2001; Larkin, Begley & Devane, 2014). The mixed method includes both approaches and when used together can contribute to existing knowledge (Gelling, 2014). Mixed methods entail both approaches functioning together so the strength of a study is greater than either selecting the quantitative or qualitative paradigm (Creswell, 2009; Schifferdecker & Reed, 2009).

The selection process of the appropriate research paradigm is reliant on how much the design deals with the research problem whilst none of the quantitative or qualitative designs are better than the other (Stewart *et al.*, 2008; Silverman, 2013). Subsequently, researchers believed that the research design selection should be based

on the context of the study, the nature of the research question and aim of the study (Crossan, 2003; Burns & Grove, 2005; Rebar *et al.*, 2011). Four different worldviews were defined by Creswell (2009, p.6) including; ‘postpositivism, constructivism, advocacy/participatory and pragmatism and their main components (Table 4.1). When planning a research study, researchers should be clear about their philosophical stance and explain why a particular paradigm was selected over others.

Table 4.1 Main components of the four worldviews

FOUR WORLDVIEWS	
Postpositivism	Constructivism
<ul style="list-style-type: none"> • Determination • Reductionism • Empirical observation, measurement • Theory verification 	<ul style="list-style-type: none"> • Understanding • Multiple participant meanings • Social and historical construction • Theory generation
Advocacy/Participatory	Pragmatism
<ul style="list-style-type: none"> • Political • Empowerment issue orientation • Collaborative • Change oriented 	<ul style="list-style-type: none"> • Consequences of actions • Problem-centred • Pluralistic • Real-world practice oriented

Source Adapted from Creswell (2009)

4.2.2 The researcher’s philosophical stance

The philosophical stance of this study’s researcher was driven by the fundamental aim of improving practice to enhance the older hip fracture patient’s journey. It was based on equity, communication and on decreasing the paternalistic effects the hospital system may have on these older patients. The researcher felt the need to prioritise empowering older patients to participate in the improvement of their journey whilst hospitalised.

As mentioned above, the most influential worldview which corresponds with this philosophical stance is the **advocacy and participatory worldview** (Creswell, 2009). This approach may change the older patients’ lives, the institutions in which individuals work (orthopaedic ward), provided that participants work collaboratively

following an action agenda (Creswell, 2009). A limitation of this approach is that since researchers are part of the culture, they may withhold results which are conflicting with their beliefs (Weaver & Olson, 2006).

The researcher of this study is an insider who implements change in her work environment. This was deemed to be consistent with a PAR approach. This approach permitted all stakeholders to engage in a communicative action (Habermas, 1984), share their views about the journey of the hospitalised older hip fracture patients and contribute towards the change process based upon their experiences and HCPs' expertise. The researcher believes that the use of PAR in this study enabled patients, their family caregivers and HCPs to communicate and collaborate in an attempt to improve practice leading to a better outcome of the older patient's journey. AR is the study of a social situation conducted by those involved in improving practice (Winter & Munn-Giddings, 2001). It is a collaborative approach which is taken to encourage individuals to take systematic action to resolve a problem (Stringer, 2014) and achieve change, whilst new knowledge about a situation is generated. Hence, the choice of the research design for this study must commence in a rigorous way by primarily considering all possible available research designs.

4.2.3 Rationale for the choice of the PAR approach.

In the positivist approach, evidence is gathered through an established plan made prior to the study and it is directed towards hypothesis testing by examining the relationship between variables (Creswell, 2009; Melnyk & Fineout-Overholt, 2011). Initially, positivism was excluded because the study aim was not to test a hypothesis or a specific treatment under controlled conditions as in experimental designs but to work towards a common goal namely to improve the care pathway of older hip fracture patients.

Quantitative methods, such as non-experimental study designs including survey research, correlational descriptive studies and cohort studies do not consider the human phenomena (Parahoo, 2014; Polit & Beck, 2017). These limitations suggested that this paradigm was inconsistent with this research and the next step was to consider the interpretivist approach which tries to gain an in-depth understanding of

individuals' experiences in personal and social environments whilst considering factors influencing them (Gerrish & Lacey, 2010; Gelling, 2015).

The use of phenomenology which is rooted in the philosophical traditions of Husserl and Heidegger (as cited in Polit & Beck, 2017) was considered. The former was in favour of descriptive phenomenology using bracketing, whilst the latter supported interpretative phenomenology also known as hermeneutics (Creswell, 1998; Polit & Beck, 2017). Although phenomenology focuses on the lived experience and tries to describe the meaning of that participant experience about a phenomenon (Thompson & Walker, 1998; Gerrish & Lacey, 2010), it does not include bringing about change thus enhancing the care pathway of older patients with hip fracture.

Furthermore, phenomenology insists that the researcher must put aside one's own experience or understanding of the phenomenon (Creswell, 1998; Craig & Smyth, 2007). In contrast, AR provides the means by which people in the health and human services may increase their effectiveness in their workplace whilst making their work more meaningful and fulfilling in complex environments (Stringer, 2014). As phenomenology highlights the meaning of lived experiences of individuals and was excluded, the use of grounded theory in this study was considered.

Grounded theory began more as an organised method of qualitative research rather than as a philosophy (Polit & Beck, 2006). It was originated by Glaser and Strauss (1967), whose theoretical origins were in "symbolic interactionism, which focuses on the manner in which people make sense of social interactions and the interpretations they attach to social symbols" (Polit & Beck, 2006, p.222). As the intent of a grounded theory is to generate or discover a theory (Creswell, 1998) AR may as well generate a theory. However, grounded theory was not deemed to be the appropriate methodological design by the researcher because it had to address problems encountered in practice whilst decreasing the theory practice gap. In fact, AR is grounded in real problems and real life situations and as the study is situated within the work setting (hospital setting), ownership of change was a priority and the goal was to improve professional practice (O'Leary, 2004 as cited in Koshy, Koshy & Waterman, 2011).

Furthermore, a case study design could have provided an in-depth analysis of the situation but it would not give the participants the opportunity to be involved in decision-making towards the advancement of patient care. Although, a case study design explores either a case or multiple cases over time through detailed, in-depth data collection involving various sources of information rich in context, (Creswell, 1998; Berg, 2007; Thomas, 2011) it does not match the purpose of this study and the researcher's roles and responsibilities. AR was selected against a case study design because it entails people to hold themselves accountable for what they are doing and assume responsibility for their own actions (McNiff & Whitehead, 2011b). Since AR is conducted in cycles of planning, acting, implementation and evaluation, it gives the opportunity to retry another solution to the problem. Moreover, it was argued that when change fails, the researchers and their participants learn from the experience when they reflect together and another plan can be formulated (Koch & Kralik, 2006; Williamson, Bellman & Webster, 2012).

Another reason why AR was chosen instead of a case study design is because the approach is supported by the values and perceptions of all stakeholders rather than by a researcher or group of researchers which are inexperienced in the care pathway of a patient with a fractured femur. McNiff and Whitehead (2009) highlight the difference between traditional research and AR. In traditional research, the researcher stays outside the research field and observes what is happening, whilst in AR the practitioner researchers position themselves in the research arena within a social context and they observe and explain what is happening to their own learning in relation to themselves and the social context (McNiff & Whitehead, 2009).

Following appraisal of the right research design, it became evident that answering the research questions necessitated the use of AR. Although, qualitative approaches were inconsistent with this study aim, AR is fundamentally based in the constructivist paradigm which aims towards obtaining clarity and understanding of research problems (Stringer, 2014). AR is about improving knowledge about present situations which is unique to the people in that particular situation, whilst sharing the knowledge and learning that guided the creation of it (McNiff & Whitehead, 2009). It supports a researcher or group of researchers to investigate an aspect of practice, to study it in detail and to plan and implement an action whilst learning occurs from

experience (Koshy, Koshy & Waterman, 2011; Kemmis, McTaggart & Nixon, 2014). AR was therefore deemed to be the right research design since the aim was to enhance the care pathway of a fractured femur patient.

4.3 The origins of action research

The origin of AR is debatable. Some writers believe that it originated in the 1940s with Kurt Lewin, (Elliott, 1991; Masters, 1995; Meyer, 2000; Koshy, Koshy & Waterman 2011). A detailed history of AR is given in Appendix 5. Most of the literature about its history identifies Lewin, a German-American social psychologist, as the founder of AR (Elliott 1991; Holter & Schwartz-Barcott 1993; Carr 2006, McCormack & Dewing 2012). Carr (2006) explains the era of Lewin and how AR was developed between the 1920s and 1950s (Lewin 1946 as cited in Carr, 2006).

Lewin, (1946) as cited in Kemmis, McTaggart and Nixon (2014), described AR in a cycle of steps including planning a change, implementing the plan into action, evaluating the action and re-planning based on what had happened. Lewin linked the idea of AR to the idea of carrying out experiments in practice rather than in the laboratory and initially, the idea of AR emerged from the assumption that the theory can be put into action (Reason & Bradbury, 2006) and can be examined on its practical effectiveness (Carr, 2006). One critique about the development of AR is that despite being actively used, AR never really advanced due to the fact that it became institutionalised in a way which nearly ensured that it could not meet the challenges for which it was originally created (Sanford, 1970 as cited in Carr, 1995). Thus, this failure was due to an increase in the separation of research and action, of theory from reality (Sanford, 1970 as cited in Carr & Kemmis, 1986).

4.3.1 Principles, definitions and characteristics of Action Research

There are various definitions of AR in the literature. Waterman *et al.* (2001) discuss that, apart from the variations within the definitions of AR, some of them focus on the characteristics of it. In a systematic review, AR was defined:

.. as a period of inquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement. It is problem-focused, context-specific and future-

oriented. Action research is a group activity with an explicit critical value basis and is founded on partnership between action researchers and participants, all of whom are involved in the change process. The participatory process is educative and empowering involving a dynamic approach in which problem identification, planning, action and evaluation are interlinked. (Waterman et al., 2001, p.11).

AR is therefore a participatory, independent process related to emerging practical knowledge which strives to bring closer action and reflection, theory and practice which can be achieved by involving others in the search for solutions about other people's concerns (Reason & Bradbury, 2006). AR also aims at resolving problems and creating knowledge established regarding a collective problem-solving affiliation amongst the researcher and the participant (Coghlan & Brannick, 2010).

Lewin, who devised the phrase 'action research,' explained the process of AR by using the following words 'planning, fact-finding and execution' (Lewin, 1952 as cited in Carr & Kemmis, 1986, p.162). In addition, AR in healthcare involves healthcare practitioners to carry out systematic queries to improve practice which, in turn, can improve their working practices and the environment of those who belong to it, such as clients, patients and service users (Koshy, Koshy & Waterman, 2011). Hart (1996) argued that although there are a variety of definitions, most writers agree that AR is problem-focused, context-specific, participative, involves change and is oriented towards improvement, and a process established on continuous interaction between research, action, reflection and evaluation.

The aim of AR varies and depends on why it is being used, by whom and for what purposes. Various researchers have explained various aims of AR. Carr and Kemmis (1986) assert that the aims of AR are twofold; to improve and to involve. AR aims at improvement by primarily improving practice, secondly by improving of the understanding of the practice by its practitioners, thirdly by the actual improvement of the situation and ultimately that this involvement goes together with the aim of improvement (Carr & Kemmis, 1986).

Waterman *et al.* (2001) states that, although there are various key characteristics, two criteria are fundamental to AR including the cyclical process of AR, which involves some kind of intervention and the research partnership. Moreover, literature explains

that the commonest characteristics of AR are that it is research in action and not research about an action, it is a collaborative democratic approach, it is research conducted simultaneously with action and finally, it is a series of events and an approach to problem-solving (Coghlan & Brannick, 2010). Also, AR is seen to incorporate democracy allowing participation of all individuals, equitability, it is liberating and life-enhancing (Stringer, 2014). There are a number of characteristics of AR in the literature and a summary may be viewed in Appendix 6.

Three pathways are described in AR practice which includes the first, second and third person research inquiry or practice (Reason & Torbert, 2001 as cited in Reason & Bradbury, 2006). The first person AR inquiry is when one questions one's own practice or life, performs mindfully, chooses fully and evaluates the outcomes in the outside world, the second person inquiry occurs when the inquiry involves others in reaching notions of common interest and the third person inquiry tries to generate a wider community of inquiry including persons who, because they cannot be recognised face-to-face, have an impersonal quality (Reason & Torbert, 2001 as cited in Reason & Bradbury, 2006).

4.3.2 Action research typologies

The purpose of this section is to discuss the various AR approaches which were developed by several researchers throughout the years. The three most common types of AR that are given in the literature are **the technical-scientific and positivist, the practical or mutual collaborative** and **the critical and emancipatory action research** (Holter & Schwartz-Barcott, 1993; Whitelaw *et al.*, 2003; Koshy, Koshy & Waterman, 2011; McNiff & Whitehead, 2011a; Kemmis, McTaggart & Nixon, 2014). Moreover, AR falls into two groups namely; there are those who believe that the researcher observes and reports what the experts are doing, which is usually referred to as the interpretive AR, whereas there is the other group which believes that the practitioner is capable of offering an explanation for his/her own doing (McNiff & Whitehead, 2011a). A brief description of each type of AR, together with a critical analysis, will follow.

The **technical model** can also be referred to as the scientific-technical or positivist action AR. The main aim of this approach is to measure and test the effectiveness of

a pre-defined intervention, whereby explanation and generalisability and the ultimate knowledge is conducted by the researcher (Koshy, Koshy & Waterman, 2011; McCormack & Dewing, 2012). Furthermore, McCormack and Dewing (2012) explain that with this approach, the decision-making process is taken by the researcher. Thus, the researcher as a participant, aims to control and improve the outcomes of his/her practice, whereby the end is known (Kemmis, McTaggart & Nixon, 2014). This model is highly criticised because participants are not regarded as experts and decisions are taken by managers which endangers ownership of both the problem and solution (Gerrish & Lacey, 2010). Conversely, this approach can be seen as one which promotes efficient and effective practice and improves personal participation by practitioners in the process of change (Masters, 1995).

The practical or mutual-collaborative is also known as the interpretivist AR (Koshy, Koshy & Waterman, 2011). This approach is associated with the interpretative research paradigm, whereby the importance is on creating meaning and the action is based on shared interpretations of social reality (McCormack & Dewing, 2012). It incorporates the inclusion of all stakeholders to identify problems, implement solutions and observe the process and result of the implemented change (Gerrish & Lacey, 2010). In comparison to the above, the practitioner in this model performs more wisely and prudently so that the outcomes of the practice will be for the best, whereas those involved are more aware that not all the outcomes can be known in advance (Kemmis, McTaggart & Nixon, 2014). Holter and Schwartz-Barcott (1993) argue that change tends to occur for a short period of time because individuals leave and hence will be replaced by new individuals with different views or there may be an influx of new individuals who enter the system. Thus, the main critique on this model is that it is dependent upon the action researcher.

The third approach is **the critical and emancipatory AR**, also known as **participatory action research (PAR)**. This approach functions on the premise that within “any system, deep-rooted ideological forces will exist that will distort the way that different individuals within it perceive reality and the effects of this will ultimately shape real experiences” (Whitelaw *et al.*, 2003, p.22). This approach is ingrained within a critical paradigm and has been influenced by the philosophers Jurgen Habermas, Paulo Freire and Brian Fay (McCormack & Dewing, 2012). In

PAR, decisions about what to explore and what needs to be changed are not taken by a single person but collectively and the aim is to explore social realities to identify whether practices have such untoward consequences (Kemmis, McTaggart & Nixon, 2014).

Table 4.2 presents a summary on the types and characteristics of AR in relation to the four essential characteristics of AR including the goal and philosophy of each approach, as described by Holter and Schwartz-Barcott (1993).

Table 4.2 Characteristics of AR

Approaches to AR	Philosophical base	Problem	Focus of collaboration	Theory	Type of knowledge produced
Technical approach	Natural sciences	Defined in advance.	Technical	Validation Refinement Deductive	Predictive
Mutual approach	Historical-hermeneutic	Defined in the situation.	Mutual understanding	New Theory Inductive	Descriptive
Enhancement approach	Critical sciences	Defined in the situation based on values clarification	Mutual emancipation	Validation Refinement New Theory Inductive Deductive	Predictive Descriptive

Source: Holter & Schwartz-Barcott, 1993

In addition to the above approaches, there is the **co-operative enquiry model** which is also known as ‘collaborative inquiry.’ This was first proposed by John Heron in 1968 when he reflected upon the ‘experience of mutual gazing in interpersonal encounters’ (Heron, 1996). Co-operative inquiry was defined by Heron (1996) as participative, person-centred query which does research with participants, not on them or about them.

Comparing co-operative inquiry with traditional paradigms, it is clear that this approach does not separate the roles of the researcher and participants. Heron was concerned about this approach for three main reasons namely; it overlaps with other

forms of PAR, only a very small number of researchers had used this approach previously and finally due to the relation between co-operative inquiry and the very broad field of qualitative research in the social sciences (Heron, 1996).

The final approach, but which is contemporaneous in literature, is **transformational AR** which promotes transformation as both end means of research (McCormack & Dewing, 2012). Transformational AR makes use of creativity and artistic illustration and is derived from an extensive understanding of knowledge whilst aiming to open embodied and artistic knowledge, as well as emotional and spiritual intelligences (McCormack & Dewing, 2012). McCormack and Titchen (2006) state that these varying forms of intelligences and knowledge are crucial in enabling ‘human flourishing’ which is the fundamental purpose of transformational AR.

Whilst acknowledging that different typologies of AR exist, they do not vary in methodology but are viewed as an orientation towards inquiry which strives to generate a quality of participation, of inquisitiveness and of questioning through the collection of evidence and assessing practices (Reason & Bradbury, 2006). Coghlan and Brannick (2010) maintain that AR as a methodological approach is established due to its collective problem-solving relationship between the researcher and participants, established with the intention of more effectively solving problems and producing new knowledge.

It became evident that answering this study question required a PAR approach which was based upon the study aim, the research questions, the researcher’s philosophical stance, as well as preparatory work conducted prior to the study and finally upon the appraisal of the typologies of AR.

4.3.3 Rationale for selecting PAR research

This approach is distinct from other AR designs since, during the process, people experience growth and learning and this occurs with everyone whether they are a researcher or a participant (Koch & Kralik, 2006; Stringer, 2014). PAR was selected over the technical approach because the process in itself has many benefits. The ideologies of participation in PAR is fundamental to health practice since a change occurs from an attitude of doing things to patients, to collaborating with people and

supporting them to ascertain their requirements and develop their self-care plans in acquiring those needs (Koch & Kralik, 2006).

In this study, a PAR approach allowed the researcher, together with the stakeholders, to identify the difficulties encountered by patients with hip fracture from admission until discharge. If a technical approach was selected, the study would have been more oriented towards the measurement and testing of the effectiveness of a pre-determined intervention, whereby explanation, generalisability and the ultimate knowledge is conducted by the researcher (Koshy, Koshy & Waterman, 2011; McCormack & Dewing, 2012).

PAR was chosen as opposed to the technical approach as it challenged the routines of the HCPs in the patient journey. Since the aim of this study was to enhance the care pathway of older fractured femur patients, new ways of working with patients together with the MDT was created by adopting the PAR approach. It was also selected because decisions are taken collectively, whilst in the technical approach, the participant researcher is the one who decides what is to be done and what is to be changed and the relationship is one-way between the researcher and the participants affected by the research (Kemmis, McTaggart & Nixon, 2014).

Furthermore, PAR was selected over the practical or mutual collaborative because it does not only aim at improving outcomes, but it helps in the improvement of self-understandings of HCPs and assists practitioners to reach a critique of their social or educational work and work settings (Kemmis, 2006 in Reason & Bradbury, 2006). If the mutual collaborative approach is selected and all stakeholders are involved and consensus is reached, there is little authoritarian views with the possibilities that implementation is perceived as being high (Koshy, Koshy & Waterman, 2011).

PAR was selected as opposed to other AR approaches because all stakeholders had the opportunity to share their views and decide about how the journey of the older hip fracture patient can be improved. Kemmis presents a convincing argument that PAR also aims to intervene in the 'cultural, social and historical processes' in daily life to rebuild not only the practice and the practitioner but also the workplace (Kemmis, 2006 in Reason & Bradbury, 2006). PAR was therefore deemed to be the

most appropriate approach in improving care pathways of older fractured femur patients.

4.4 PAR: Approach to enhance journey of older hip fracture patients

When compared to traditional research, PAR is different in that research is followed by action, whereby this action is researched, changed and re-evaluated collaboratively by the participants. It provides an opportunity for the stakeholders to open a ‘communicative space’ (Habermas, 1984) to discuss and explore participants’ concerns in relation to the journey of the older fractured femur patient. In this PAR study, this means that the researcher is not observing issues from her own perspective but through open communication. It involved a collaborative approach which included the involvement of all stakeholders. ‘A basic action research cycle’ was used which included three steps of “LOOK, THINK and ACT” (Stringer, 2014).

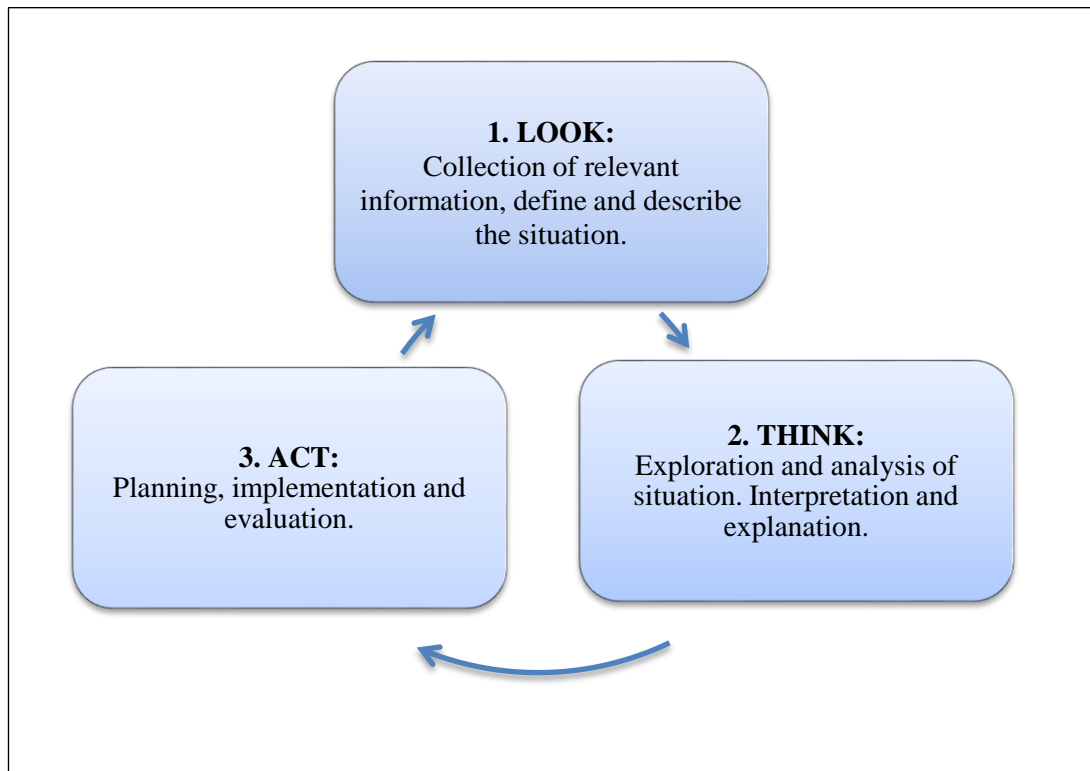
4.4.1 The three steps of the action research cycle used in this PAR

This study included the three steps of **LOOK, THINK and ACT** (Stringer, 2014). This acted as a framework to assist the group when it came to developing their questions in an uncomplicated manner whilst providing further detail when the subject became more complex. The first phase (LOOK) is where participants describe the problem, providing relevant information which surrounds it and which concerns them.

The second part (THINK) incorporates an analysis and interpretation of the situation to further increase all participants’ understanding of the nature and context of the issue. Finally, the third phase (ACT) is when solutions are planned, applied into practice and evaluated (Stringer, 2014).

There are other AR routine cycles, such as those developed by Lewin (1946), Elliot (1991) and Kemmis and McTaggart (2014). Stringer’s (2014) basic routine was preferred since it provides a systematic way of working together in cycles of ‘looking, thinking and acting’ and is widely used in nursing AR studies. Nonetheless, Stringer (2014) maintains that various formulations of AR cycles exist which suggest the same set of actions with similar processes (Figure 4.1).

Figure 4.1 An action research routine (Stringer, 2014)



4.5 Application of the action research method within the mini cycles

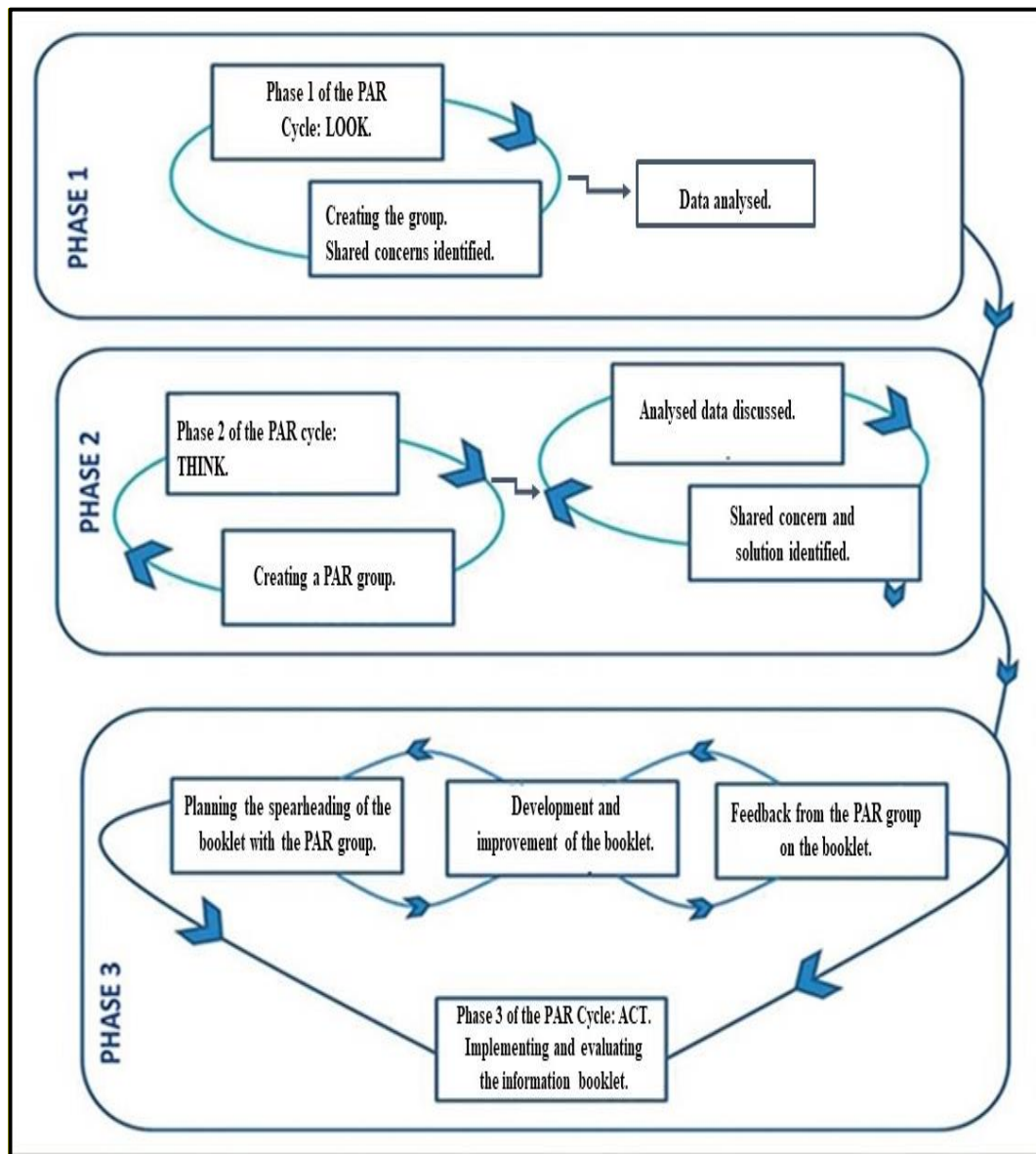
The section above explored why PAR was selected over other traditional research designs and why it was selected over the technical model and the mutual collaborative action research. PAR allows the action to be investigated and it is not just a piece of research followed by action but the action under research can be changed according to the findings and re-researched together with the research participants. This is further supported by Polit and Beck (2006) who explain that in PAR, there is an association between the participants and the researcher in defining the problem and selecting an agreed approach. They continue to argue that the aim is not only knowledge production but the action and raising awareness amongst participants, as well. In the light of such an argument, according to Coghlan and Brannick (2010, p. 35) action research has been defined as a methodological approach which is founded on a “collaborative problem solving relationship between researcher and client which aims at both solving a problem and generating new knowledge.” Within this PAR cycle, various processes (mini-cycles) were conducted throughout, which will be explained below.

4.5.1 Learning acquired through the PAR Cycle.

The application of the PAR cycle is described within each of the mini-cycles in Figure 4.2. It presents the PAR cycle which contains mini-cycles of activity. The first phase of the study, 'Look' included the creation of the group to identify shared concerns whereby data was continuously analysed. This phase led to the 'Think' Phase, where an action group was created. The data analysed was discussed individually with the participants where a problem and a solution were identified. In the 'Act' Phase, mini-cycles of development, improvement and feedback were continuously conducted in order to implement and evaluate the information booklet.

A discussion about how participants were engaged in this PAR cycle is discussed in Section 5.10. Stringer (2007) explains that, although AR does not resolve all relevant problems, it provides an opportunity for the participants to work collaboratively on their situations and to devise effective solutions to difficulties they encounter in their lives. A PAR cycle allows participants to learn from their experiences throughout the entire cycle which is organised through 'LOOK,' 'THINK' and 'ACT.'

Figure 4.2 The application of the PAR cycle within mini-cycles



This PAR cycle helped the researcher to understand the world of older patients with a fractured femur when they are admitted unexpectedly to hospital. Although, the final aim of this PAR cycle was to enhance the patient care pathway, the process helped the researcher to explore and work collaboratively with all stakeholders. The commitment demonstrated by all stakeholders encouraged and confirmed the researcher’s decision of selecting participatory research. Whilst PAR goes far beyond the traditional research process, it helped the researcher to acquire balance between all participants and maintain a more equal level of power and influence throughout this research process.

An additional learning experience or achievement throughout this PAR study was that all participants were regarded as equal collaborators generating knowledge and eventually, an action towards enhancing the care pathway was able to be implemented and evaluated. Subsequently, the entire project provided the researcher with an opportunity to learn how to work and plan research with the patients (researched) and HCPs, to be self-critical and continuously evaluate power inequality, considering that Malta is still somewhat dominated by the medical profession. Furthermore, the researcher acquired skills on how to work and acknowledge various participants with different perceptions, knowledge and agendas. By taking part in the first mini-cycle the researcher learned how to be an insider and to be able to search for more information about the patient care pathway. The researcher believed that she should obtain this knowledge from the very start, since knowledge informs practice and vice versa, since there is the theory practice gap where both elements are required for good quality care.

Various meetings were organised prior to the planning phase of this 'Look' Phase. During these meetings experiences and knowledge were shared between various stakeholders. These meetings helped the researcher to understand the importance of the multiple roles involved when HCPs are caring for these patients and to understand the important work which was undertaken by the community nurses. In Phase 1 (Look Phase), the researcher learned how and where to search for information as she was keen to involve everybody equally and to minimise power inequality as much as possible. The researcher tried to involve all the participants in the 'Look,' 'Think' and 'Act' Phases of this PAR cycle since she considered their input to be valuable when it came to identifying the problem and providing a solution.

The first mini-cycle of the Look Phase taught the researcher to communicate effectively with all stakeholders, to explore concerns raised, dissatisfactions, as well as problems encountered during the patient care pathway. This was a process which helped the researcher open a communicative space and not be a lone researcher studying these issues from her own viewpoint. Furthermore, this phase helped the researcher to become an insider whilst identifying what participants were doing, what ideas were important to various stakeholders and how different stakeholders'

ideas were changing. As a result of this process, the researcher was able to realise and reflect on who to include in this cycle and who the important stakeholders were. Moreover, the researcher discovered how to proceed sensitively with others who may or may not have been so keen to participate in identifying the shared concern. During this mini-cycle, the researcher learnt how to provide a comfortable environment for participants, she found ways in which to allow them to talk during the interviews without being critical and she gained skills on how to motivate people to discuss the identified concern and solution.

In the Think Phase, the researcher learnt from the experiences of others and through the information obtained from the data collection. This helped the researcher and the participatory action group to decide on a solution to the identified problem. The second mini-cycle helped the researcher to confirm her own ideas, experiences and level of knowledge, gained through practice. These were affirmed by people with the same experiences and by HCPs who completely understood the context. The researcher learnt that she was not alone throughout this whole process. Essentially she learnt how to question practice. Besides, the researcher found ways in which to respect and give importance to the ideas put forward by others, how to be flexible and adapt to the requested changes. The teamwork and enthusiasm demonstrated by the participatory action group highlighted and strengthened the need for more information giving.

The Act Phase, which included various mini-cycles of planning, feedback, improvement, implementation and evaluation, helped the researcher move from a viewpoint of doing 'things' for patients towards working with the stakeholders to identify the actual needs of older patients with fractured femur. This cycle helped the researcher to work in a team and accept constructive criticism.

Routine work processes were challenged and reflection helped the researcher to build on her self-confidence. Throughout the whole PAR cycle, the researcher learnt to trust others and to understand that action research is a method which takes the researcher and the participants through different routes which sometimes are not straight forward or expected but which encourages the group to move towards new, unexplored pathways. Finally, when conducting an action research study the

researchers ensure that communication with others are opportunities for learning and development (McNiff & Whitehead, 2002).

4.6 Conclusion

This chapter presented a detailed explanation as to why PAR was selected over other research approaches such as phenomenology, case study and grounded theory. The main characteristics of AR were discussed. A PAR approach allowed the researcher to work with the stakeholders to identify a problem encountered by patients with hip fracture from admission until discharge. A brief discussion about what was learnt during this PAR cycle was also highlighted. How this PAR study was conducted using a basic routine cycle of **LOOK, THINK and ACT** (Stringer, 2014) in the care pathway of older fractured femur patients will be described in the next chapter.

CHAPTER 5

METHODS

5.1 Introduction

This chapter presents the research aim and objectives together with a detailed explanation of this Participatory Action Research (PAR) Cycle. It provides a discussion how this cycle was initiated from acquiring access to the research site through to devising the interview guides, attaining ethical approval, population and sampling technique, methods used in data collection and data analysis.

5.2 Aim of the study

The aim of the study was to improve the journey for those older fractured femur patients from admission to hospital to their eventual recovery and discharge into the community.

5.2.1 Objectives of the study

To attain this study aim, the following objectives were formulated:

- To explore stakeholders' (patients, their ICs and HCPs) views of the current care pathway for the older fractured femur patient from admission to discharge into the community.
- To identify facilitators enhancing the care of these patients in hospital and in the community.
- To analyse the readiness for change in the journey of these patients in collaboration with the stakeholders.

Other objectives were set on answering these objectives and in the process of A Basic Action Research Routine Cycle (Stringer, 2014). These include:

- Exploring the views of the stakeholders on the provision of information-giving to fractured femur patients and their ICs, from admission to hospital and subsequently in the community.
- Evaluating stakeholders' impact on the information booklet developed for fractured femur patients, their ICs and the HCPs.

5.2.2 The research questions

The resultant research questions are as follows:

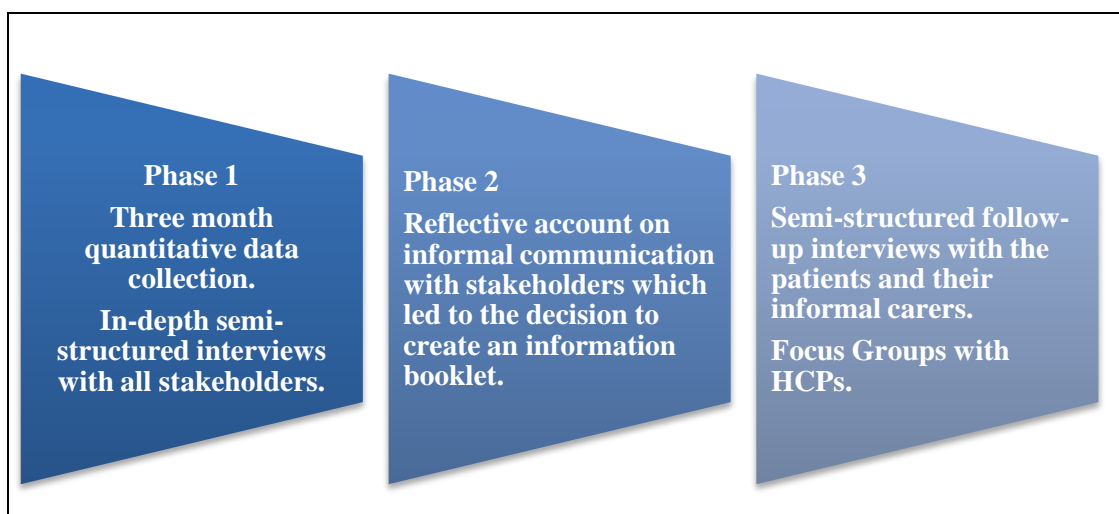
1. What are the current care pathways available for older fractured femur patients from admission to discharge into the community?
2. What are the perceptions of the stakeholders on the current care pathway of these patients?
3. How can the provision of care in hospital and subsequently in the community for the older fractured femur adult be enhanced?
4. How can patients, their ICs and the HCPs be involved in the care of such patients in hospital and in the community?
5. What information can be provided to improve the patient's journey?

5.3 PAR process: Enhancing journey of older fractured femur patient

In PAR, the researcher's role is recognised as being that of a **research facilitator**. The person in this role becomes committed to a specific pathway and needs to think differently and clarify with others how things are to be conducted and whether what is done is influenced by rituals (Kemmis, McTaggart & Nixon, 2014). In this study, the researcher adopted the role of a research facilitator and collaborator. The terms 'researcher' and 'research facilitator' are used interchangeably throughout.

Figure 5.1 outlines the methods of data collection utilised in this PAR Cycle. These will be further discussed in later sections.

Figure 5.1 Methods of data collection in this PAR Cycle



In this study, a set of eligibility criteria was established to assist the researcher in the sampling of participants. This criteria is based upon the importance of selecting individuals who are experienced or affected by or have an impact on the issue being studied (Stringer, 2014). Eligibility criteria for each participant group and rationale for each are presented in Tables 5.1, 5.2 and 5.3.

Table 5.1 Eligibility criteria for identifying the HCPs

Criteria of HCPs		
Inclusion criteria	Exclusion criteria	Rationale
HCPs (multidisciplinary) working in the trauma orthopaedic ward in the acute hospital in Malta.	HCPs who work in trauma orthopaedic wards in private hospitals in Malta or Gozo.	To obtain input from HCPs who have direct contact and experience with older patients with fractured femur.
HCPs working in the ward where the study is being conducted.	HCPs who carry out domestic work and do not have patient contact.	
HCPs with at least two years' experience in the role and working days and roster.	HCPs with less than two years' experience.	

Table 5.2 Eligibility criteria for identifying the patient participants

Criteria of patients with fractured femur		
Inclusion criteria	Exclusion criteria	Rationale
<p>People aged 65 years and over living in Malta admitted to the acute hospital with traumatic hip fracture.</p> <p>Patients admitted from home, other hospitals or institutions.</p> <p>Patients with or without informal carers.</p>	<p>Patients with complicated conditions, for example, pathological fracture.</p> <p>Participants living in Gozo.</p> <p>Participants who are tourists.</p>	<p>To collect data on older persons with hip fracture due to a fall.</p> <p>The care pathway, length of stay and rehabilitation of older patients with hip fracture in Malta may vary from that in Gozo.</p> <p>Tourists would leave hospital earlier and cannot be followed up after discharge.</p> <p>To include all possible stakeholders who experienced or are involved in any way in the journey of the older patient with hip fracture.</p>
<p>Patients having the capacity to consent to participate in this study.</p>	<p>Patients suffering from cognitive disorders, such as dementia and other communication problems.</p>	<p>To collect data with patients capable to communicate and maintain a conversation.</p>
<p>Patients under the care of orthopaedic surgeons.</p>	<p>Patients under joint care such as, under the medical doctors or surgeons.</p>	<p>To eliminate variables which might have an influence on the views of the stakeholders</p>

The chosen age of patients was 65 years or older and was based upon the Maltese retirement age. In medical research, the ‘elderly’ are usually defined as being over the age of 65 (Sabharwal *et al.*, 2015) and the United Nations uses the age of 65 as a cut-off point for older persons (United Nations Population Fund, 2012). Older fractured femur patients with no ICs or from an institution were also included since their contribution was considered to be as important as those with family support.

Table 5.3 Eligibility criteria for identifying the informal carers

Criteria of informal carers of patients with fractured femur		
Inclusion criteria	Exclusion criteria	Rationale
ICs keen to participate and who have the capacity to give consent.	ICs suffering from cognitive disorders, such as dementia and other communication problems.	To collect data with ICs who are able to communicate and maintain a conversation. (Able to open an effective communicative space).
ICs close to and living with those older patients who have sustained a fractured femur after a fall.	Neighbours or ICs (plus formal cares) not living with the patient and who are unable to recount the patient's needs and his/her experience of hospitalisation.	To include all possible stakeholders experienced or involved in any way in the journey of the older patient with a hip fracture.

5.4 Phase 1 of the PAR Cycle: LOOK

This PAR is initiated by the LOOK phase which is composed of an exploration of a shared concern, as experienced by various people involved in and affected by a practice (Kemmis, McTaggart & Nixon 2014; Stringer, 2014). Therefore, this fact-finding phase obtained data from various stakeholders including older hip fracture patients, their ICs and HCPs.

5.4.1 Creating the group and opening a communicative space

The first cycle included the preparations undertaken for the identification of the problem. It commenced with the first step, LOOK in Stringer's (2014) basic routine which included the identification and creation of the group to **open a communicative space** for participants to communicate and share their concerns. To gain access to the research site and create the group of participants the research facilitator was required to carry out some preparatory work.

This preparatory work was necessary for two main reasons. Primarily, when writing the study proposal, the research facilitator was still an outsider to the research area even though she used to work at the orthopaedic operating theatres. However, the context was different. Therefore, there was the need to establish and identify all

stakeholders and get acquainted with the ward environment. Secondly, stakeholders' views on the study and permissions to enter the research site were required and thus, various meetings were organised. A reflective account on these preparatory meetings can be viewed in Appendix 7. This was supported by Stringer (2014) who stated that determining the official structure of the organisation and communicating with individuals of influence is an imperative task for action researchers to gain access to the research site. Moreover, informal communication with older patients known to the researcher (neighbours and relatives) highlighted issues of concerns and how they felt when they were hospitalised because of a hip fracture.

This phase of opening a communicative space, identifying what exactly needs to be investigated and identifying who would participate in this **public sphere** may take time until the research facilitator identifies the right participants who are committed to examine a shared concern (Kemmis, McTaggart & Nixon, 2014). In fact, this preparatory work and approval of first ethical permission took a year to be completed. However, all this foundational work made it possible for the researcher and everyone concerned to recognise the need for this PAR which required further exploration (Kemmis, McTaggart & Nixon, 2014).

5.4.2 Shared concerns identified

The first phase commenced by opening a communicative space in which stakeholders were encouraged to talk about what they wanted to change or add in the current care journey. The researcher ensured that the first established group included everyone and acknowledged that they were free to talk, irrespective of their role, status, knowledge or power. Kemmis, McTaggart & Nixon (2014, p. 92) explain in Habermas's view that individuals need space and permission to talk freely in "public spheres" which are settings for discussing perceptions, intentions, points of view, expected outcomes, knowledge, values and responsibilities. It is called "public sphere" because each and every one them ...

... strive to overcome the constraints on open discussion that typify ordinary institutional life, when speech and action are often constrained by institutional or organisational norms about how people in different kinds of roles and positions will ordinarily behave and speak. (Kemmis, McTaggart & Nixon, 2014, p.92).

In Habermas (1984) communicative action there are the three validity claims (truth, rightness and truthfulness) which are embedded in the speech act that has helped this communicative process in this research to be real, genuine and valid. Kirkpatrick (2003) states that the TCA's (Habermas, 1984) central role involves agents participating with other individuals who are all recognised as equally competent in conversations intended only to obtain the truth. Therefore, during Phase 1 of this study, the researcher ensured that everyone spoke openly and honestly about their concerns at all times. She also emphasized her role of facilitator with all the stakeholders. She verbally explained to all the participants that there was no right or wrong answer and that every honest answer was vital for the improvement of the older hip fracture patient's journey.

In the Habermas (1984) theory, the principles of **communicative action** were exerted in this initial phase and stakeholders entered a communicative space from the usual **strategic action** to open dialogue and identify a shared concern. This process of discussion of **strategic action** and **communicative action** provided an opportunity for stakeholders to discuss what they needed to change in the care. This dialogue between strategic and communicative action is a conversation that takes place in a PAR study about what to change and often includes; purposes, roles, structures and rules of the organisation (Kemmis, McTaggart & Nixon, 2014). As stakeholders answer questions about what they need to change, they can repair or build new lifeworld relationships that give them an opportunity to recognise and respect others holistically as unique individuals (Kemmis, McTaggart & Nixon, 2014).

Habermas (1987) also explains the affiliation between **system** and **lifeworld** as a relationship amongst two concurrent, aspects of social life and interaction. Also, lifeworld processes occur when people encounter each other as persons who are essential to organisational systems (Kemmis, McTaggart & Nixon, 2014).

In Phase 1, all participants were encouraged to identify their concerns and provide solutions in relation to the journey of the older hip fracture patient. Each older patient and IC was invited to discuss their views whilst the patient was hospitalised. Since older fractured femur patients were limited in their mobility, creating repeated

group discussions was not possible, hence individual semi-structured interviews were conducted. HCPs also discussed their role in this care pathway.

Stringer (2014) suggests that, in this initial stage, all stakeholders are intentionally involved in collecting information and in describing the problem. Sample size and sampling methods together with methods of data collection of Phase 1 in this PAR Cycle are presented below.

5.4.3 Research setting and gaining access

The orthopaedic trauma ward where the study was conducted contains twenty-four beds in the acute general hospital in Malta. Older patients with traumatic hip fracture are admitted every alternate day either to the study ward or to another twenty one bedded ward. The first step was to obtain baseline information. This occurred over a period of three months during which time, quantitative data collection took place by the researcher in the orthopaedic trauma ward.

The next step was to establish contact with all the stakeholders through one-to-one semi-structured interviews. These initial interviews commenced with a discussion of the information letter and the purpose of this PAR research. The interviews were conducted at a convenient time and place as selected with the participants themselves. This was specifically important with those older patients who were experiencing limited mobility and postoperative pain. This helped participants' have a sense of ownership and feel involved since their feedback was vital to this study.

5.4.4 Population under study: Identifying the stakeholders

Qualitative and AR studies require the researcher to purposely select people based on a specific set of characteristics (Stringer, 2014). Selecting the most related rich sources of data available to understand the meaning of the experiences, whilst recruiting individuals who are part of the phenomenon being studied is vital (Rebar *et al.* 2011; Patton, 2015). In this PAR Cycle, a purposive sampling technique was used to generate in-depth and rich data. This sampling technique does not incorporate random sampling but selects 'information-rich' sources which, by their nature, will inform the research question under investigation (Patton 2015, p.264). The strength of purposive sampling is based upon this selection of 'information-rich'

cases which provides in-depth understanding rather than generalisations. Volunteer/convenience sampling was used with a captive population, in order to gain broad information. Although volunteer sampling is not a preferred approach, it is efficient to begin the sampling process (Polit & Beck, 2017). It is inexpensive and an excellent means of obtaining initial information on the research topic (Berg, 2007; Gerrish & Lacey, 2010).

5.4.5 Recruitment and sampling technique for interviews for Phase 1

Participants in Phase 1 were recruited at the hospital personally by the researcher who approached the patients and their ICs prior to discharge. Those participants who had an expected discharge date were contacted by the researcher two days before their discharge so that they had enough time to decide, whilst not feeling coerced to participate. Also, those patients who were without a discharge date, but were imminently awaiting discharge by their orthopaedic consultant, were also informed about the study. An information letter and consent form either in Maltese or in English, together with a verbal explanation, was given to the patients and their ICs (Appendices 8A – 9D). Time was given for them to decide whether to participate.

Patients who were awaiting transfer to the rehabilitation hospital were also recruited. The date of such transfers are generally not known until just before the actual transfer. When the researcher recognised that a transfer was imminent, she approached the patient and his/her IC and briefed them about the study prior to their transfer. An information letter and consent form were also given. Two days after the actual transfer, the researcher visited them at the rehabilitation hospital. Two days were allowed so that the participants would have enough time to adjust to the new environment (rehabilitation hospital) and to decide about their participation in this study. Koshy, Koshy and Waterman (2011) recommend twenty four hours to allow individuals to decide if they wish to participate. Conversely, the researcher did not wait more than two days as some rich data might have been lost due to forgetfulness as time elapsed. Upon acceptance, an interview appointment was scheduled.

Parahoo (2014) states that researchers must give as much information as possible in order to obtain a consent form. Prior to each interview, the researcher asked participants about any concerns they might have or if they wanted to ask any

questions. When all questions were answered and participants appeared satisfied with the information given, the consent form was signed. Very few questions were asked by the older patients and were mainly related to their proficiency in answering the interviewer's questions. In the case of HCPs, the researcher introduced the research aim and an information letter together with the consent form were given (Appendices 10A-10D). The following day the consent form was returned and a date, time and place for the interview to be conducted was selected with the HCPs.

5.4.5.1 The sample in Phase 1

The sample consisted of older patients with fractured femur (n=16), ICs (n=12) and HCPs (n=17). The sample of the patients with hip fracture and ICs was paired to minimise other influencing variables such as, the degree of support provided by the ICs to the patient. The total number of patients and ICs does not match since one patient interview had to be discontinued since she was in pain and not very communicative. A patient did not have any ICs. There were another two participants who were due to be discharged home from the rehabilitation hospital and unfortunately the researcher had not managed to contact their relatives. These interviews (n=2) were not discarded since new and valuable information had been given by the participants. The sample size was decided when data saturation had been achieved. There are no instructions about the sample size in qualitative research but the principle of data saturation is applicable when the same themes and categories keep recurring and no additional information is collected by additional data collection (Pope, Ziebland & Mays, 2000, Melnyk & Fineout-Overholt, 2011; Polit & Beck, 2017).

Lincoln and Guba (1985) defined this as informational redundancy denoting that no new evidence is generated from new participants. When appraising qualitative research, data saturation is a key notion in recognising scientific rigour (Kanji, 2012).

5.4.6 Methods of data collection in Phase 1

Various research instruments were utilised in this PAR which included three month quantitative data collection and one-to-one semi-structured interviews.

5.4.6.1 Quantitative data collection in Phase 1 of the PAR Cycle

This three month quantitative data collection was conducted to collect demographic data in relation to the target population. The objective was to explore the older patient's length of stay, discharge destination, age category and gender.

This data was collected by the researcher by taking note of the ward census on a daily basis on how many patients were admitted to the research ward over a period of three months. The data collected was on older patients admitted with a fractured femur after a fall between the months of May to July 2013. On each census, near each patient's name, the researcher documented information on the diagnosis and compared each census every day to identify any new admissions. When a patient was discharged from the research ward, the destination and length of stay was documented. There were days when the researcher was not on the ward. In her absence, a ward clerk kept updating the census so that no data was lost. The researcher then reviewed this on her return.

The baseline data was important in this PAR because it helped to identify the stakeholders and to explore what was happening in practice. It helped to obtain data on patient admission and discharge destinations, including those from institutions. It also quantified patients' death rates in the orthopaedic ward.

Having obtained a preliminary picture about the identified concerns through informal communicative action with stakeholders and baseline data, this study progressed to the semi-structured interview.

5.4.6.2 Qualitative interviews in Phase 1 of the PAR Cycle

The primary purpose at this phase of the study (LOOK) was to collect information and explore the older patients, their ICs and HCPs perceptions on the care pathway.

Despite interviews being time-consuming and there is always a risk of bias to validity issues, they tend to have higher response rates, they allow the researcher to explore in-depth meaning and they have proven to be very effective with certain groups of participants such as the elderly and those people who are illiterate (Burns & Grove, 2005; Gerrish & Lacey, 2010; Koshy, Koshy & Waterman, 2011).

Furthermore, interviews are useful when exploring a situation from other people's point of view. This method of in-depth, semi-structured interviews was selected over others, such as unstructured interviews, because it was important to ensure that all the issues of the entire journey of the older hip fracture patient was discussed with all stakeholders (Polit & Beck, 2017).

An unstructured interview schedule in the initial phase would be ideal, especially when an action researcher would like to keep his/her options open with regard to the questions asked. It is then possible to switch to a semi-structured approach when clearer information is obtained (Elliott, 1991). Given that the researcher was an insider, exploratory work was conducted and other sources of data at this phase were collected, which permitted the researcher to use semi-structured interviews.

Elliott (1991) points out that when semi-structured interviews are utilised, interviewees should be provided with an opportunity to raise their own topics as the interview progresses. For this reason, an open question asking participants whether they would like to add any comments which had not been discussed during the interview was added in all interview guides.

Semi-structured interviews were selected over telephone interviews or questionnaires since this method allowed the researcher to observe non-verbal cues and allowed the building of a rapport in a calm, friendly environment for the older patient and enhanced participation (Opdenakker, 2006). Evidence also shows that telephone interviews are more feasible when sensitive topics are investigated (Mealer & Jones, 2014).

Semi-structured interviews were selected over questionnaires since some of the older participants were unable to fill in the questionnaire due to their poor vision and literacy difficulties. Various authors have observed that information obtained from questionnaires tends to be more superficial than from interviews (Oppenheim, 1992; Stewart *et al.*, 2008; Polit & Beck, 2017).

5.4.6.3 The semi-structured interview guide

A well-constructed interview guide is imperative to collect information which can be easily managed during the analysis, whilst it helps to discover the unpredicted and the unknown (May, 2002; Denzin & Lincoln, 2011). Drafting the interview guide required the researcher to be cautious during the formulation of the questions and it was important not to differentiate between participants' status and knowledge. Primarily, all questions were constructed to be to the point, understandable and jargon-free. The wording, as well as the construction of the questions, was important because it can lead to deviation from the subject, to unclear responses and may cause the whole interview schedule to be insignificant (Patton, 2015). Precautions were taken since the researcher needed to make sure that the questions posed do not imply judgement or criticism (Stringer, 2014; Patton, 2015).

Each group of participants, namely patients, ICs and HCPs had an interview guide which were provided in two languages; Maltese and English. These will be discussed in the next sections. To enhance trustworthiness, all interview guides were translated rigorously by two educational academics in the Maltese and English language, respectively. Consequently, the English interview guides were translated into the Maltese language by the Maltese expert. Subsequently, the Maltese guides were back-translated by the English lecturer to enhance rigour.

The patients' interview guide was formulated in a logical sequence and was divided into two parts depending on the discharge destination. The first part focused on the perceptions of the patient journey, starting from admission to the emergency department until discharge from the acute hospital (Appendices 11A & B). The second part focused on the journey starting with admission to the rehabilitation hospital to discharge home including their perceptions on community services and intermediate care (Appendices 12A & B). The first question in the interview guide was a general question inviting the older patient to discuss their pre-fracture health status. The interview guide included prompts which enabled the research facilitator to pursue clarification and get more information, whilst precautions were taken to ensure that participants were not influenced by any interviewer comments (Burns & Grove, 2005; Parahoo, 2014; Crowe, Inder & Porter, 2015).

The above precautions were also adopted during the development of the semi-structured interview guides for ICs which contained the same themes as that of the older patients, with the exception that questions were directed towards their perceptions as relatives (Appendices 13A & B). The interview guide for HCPs focused on how professionals perceive the care pathway of older fractured femur patients from admission until discharge (Appendices 14A & B). To test and identify any issues with the interview guides a pilot study was conducted.

5.4.6.4 Pilot study

Carrying out a small research study to test the methods before the actual study is a characteristic of a good research study (Rebar *et al.* 2011; Silverman, 2013). Prior to the pilot study, the research facilitator referred to the literature (Gerrish & Lacey, 2010; Patton, 2015; Polit & Beck, 2017) on qualitative interviewing to better understand the required skills for conducting interviews. The pilot interviews in this PAR were conducted for the following purposes:

- To test and improve the interviewer's skills to obtain further practice in interviewing.
- To test the interview guide and enhance practice in transcription.
- To ensure that the questions were comprehended by older patients.
- To ensure that the questions reflected the outcome of the discharge destinations.

A pilot study was conducted prior to the actual study with two older hip fracture patients with different discharge destinations. Prior to the interviews, the two older patients were briefed about the aim of the pilot study and an information letter and consent form were duly signed. One patient was discharged home, and she did not have any ICs. The other patient, who was transferred to the rehabilitation hospital, was interviewed together with her IC by the researcher at that hospital. Once she had been discharged home, another interview (Part 2) took place at their home. Pilot interviews were conducted in Maltese and no questions were found to be misunderstood by the patients. Interviews were transcribed immediately upon

completion and were reviewed by the supervisors and an expert in orthopaedics (Practice Development Nurse [PDN]) for suggestions and recommendations.

The pilot study with patients and their ICs revealed a need for improvement in interviewing skills, especially with making better use of prompts. For example, one of the patients explained that she had experienced uncertainties upon discharge home. It was suggested that probes should be utilised to explore these uncertainties. The pilot study also demonstrated that participants should be informed about what to expect from the interview prior to the actual interview and a distinction should be made about the dual role of the researcher. Hence, it was decided that at the beginning of the interview the researcher should explain to the participants that if they had any issues related to nursing care, these should be dealt with at the end of the interview. This made them feel at ease to speak, ready to communicate and that they were going to be helped with their concerns.

Participants' questions related to problems with their hospital stay (e.g. attending orthopaedic out-patients appointments) were answered at the end of the interview in order to minimise respondent bias and avoid deviation. During the interview, the role of a research facilitator, as opposed to a nurse or charge nurse, was explained to the participants so that honest responses were encouraged. The researcher discussed the overall results of pilot study with her supervisors and it was agreed that the data collection from just the second interview would be included in the main data collection, due to its rich information.

The HCPs' interview guide was discussed with the PDN and supervisory team to assess whether the interview guide was comprehensible. A pilot study was also conducted with a nurse for the researcher to gain confidence when interviewing colleagues. The results of the pilot studies for HCPs showed that no major changes were required in the interview guides and that the data collected from this interview were included in the main data collection.

After reviewing the results of the pilot studies, the researcher felt more confident to proceed with data collection. This is outlined in the next section.

5.4.6.5 Data collection of interviews in Phase 1 of the PAR Cycle

All interviews were audio-recorded which allowed the research facilitator to have the available information stored accurately and in a detailed format (Opdenakker, 2006; Stringer, 2014). On completion of each interview, the researcher transcribed verbatim the interviews within one to two weeks of the interview and notes were documented immediately. When non-verbal cues, nods, emotions and facial expressions were noticed, the researcher documented these cues in her field notes taken during the interviews. This enabled the researcher to record visual data that might have been lost or unavailable if one had to rely only on audio-recording (Silverman, 2013). These cues and possible meanings were documented in the interview transcript. The above was done to ensure that the transcriptions were done rigorously, that nothing was unwittingly changed, especially with connotations and to enhance better data analysis (Polit & Beck, 2017).

As participants were given the option to select the preferred language to be used during the interview, the majority selected the Maltese language. All patients (n=16) with a fractured femur and their ICs (n=12) selected Maltese whilst seven out of seventeen of the HCPs opted for the interview to be conducted in English. The interview time excluded the time taken for the researcher to describe the objectives of the study. This was deemed necessary to enhance communication by ensuring that the stakeholders had the necessary information about the study.

The average length of the patient interviews was of sixty minutes with the shortest lasting twenty two minutes and the longest lasting a hundred and thirty minutes. The interview which took only twenty-two minutes was conducted with a patient who was waiting for a bed at an institution. This patient seemed limited in her discussion as, throughout the interview, her emphasis was mainly on going to an institution. Patient interviews were conducted at the rehabilitation hospital and continued at their home/previous residence or immediately at home.

The ICs' time varied between thirty minutes to ninety minutes with an average of fifty minutes. The ICs interviews (n=12) were conducted either at the patients' home or at a convenient place chosen by the IC. These included patients' homes, a private

respite home for the elderly and informal carers' work place including an office in a confectionary shop, slimming club and at the acute hospital.

The average length of the interviews of the HCPs was of forty minutes with the shortest lasting thirty minutes and the longest lasting sixty five minutes. Interviews were mainly conducted in the orthopaedic trauma ward. Only four HCPs preferred a different place including the hospital canteen (n=2), one at the rehabilitation hospital and another nurse at her home.

5.5 Phase 2 of the PAR Cycle: THINK

In the second phase, analysed information that emerged from responses to questions offered understanding from which actions to solve the situation were formulated (Stringer, 2014). The analysed data which was obtained from Phase 1 revealed consistency in responses amongst all stakeholders. Concerns felt and discussed by the stakeholders were predominantly about the need for more information required during the patients' care journey. Throughout the interviews, the patients and their ICs discussed the need to receive more information about certain essential issues within the care pathway. On this point, the HCPs responses complemented those of the patients and their ICs.

There is explicit evidence in the literature about the benefits of information-giving when a person is hospitalised. Hence, it was suggested by various stakeholders from the first data collection (Phase 1) that more information-giving offered the best solution to improve the journey of the older hip fracture patient.

Stringer (2007, p.122) states that in small groups, the interpretation and analysis part may be included in "processes that move more directly from description, through interpretation, to problem-solving." Stringer continued that sometimes research participants may communicate a plan immediately since the analysis recognises a single problem requiring attention (Stringer, 2014). The analysis from the data collected in the LOOK Phase identified a robust and persuasive need for information-giving during the older patient journey from admission until discharge. Hence, a **Participatory Action Group** (PAG) of two female patients and their ICs, a

geriatrician, an orthopaedic surgeon, a nurse, a physiotherapist, an occupational therapist, a medical illustrator practitioner, the orthopaedic PDN and the research facilitator was established for Phase 2. All participants for the Planning Phase (ACT) were stakeholders from Phase 1, except for the medical illustrator practitioner and the orthopaedic PDN. Informal communication was held on a one-to-one basis with the participatory action group, to discuss the felt concerns whilst all participants agreed to participate in the next stage. Further details about the informal communication which took place in Phase 2, is given in Appendix 15.

5.6 Phase 3 of the PAR Cycle: ACT

The **ACT** part is divided into the **planning**, the **implementation** part and **evaluation**. In the planning phase, research facilitators join the stakeholders to develop actions that need to be implemented (Stringer, 2014). A priority was given to the development and review of an information booklet (Appendices 16 & 17) by the participants together with the research facilitator who committed themselves to contribute in this process. Information on the booklet was mainly based upon the information all stakeholders requested in the communicative action process in Phase 1 of this PAR Cycle. After identifying the priority for action (development of the information booklet) participants should plan responsibilities and individuals need to ensure that their responsibilities were made clear (Stringer, 2014).

5.6.1 The planning and development of the information booklet

The participatory action group of Phase 2 agreed to entrust the research facilitator with spearheading the booklet. This involved information gathering from stakeholders' data in Phase 1, preparing the text and ensuring that all the expert advice given was in line with clinical practice.

The medical illustrator practitioner took the responsibility, together with the research facilitator, to develop the graphics of the booklet. The information booklet was then drafted and translated into Maltese. The same translation protocol for the interview guides was used for the translations of the information booklet.

The information booklet was divided into nine colour-coded concise sections including information from admission until discharge from hospital and subsequently into the community.

5.6.2 Feedback received on the information booklet

The purpose of consultations with the participatory action group was to ensure that the stakeholders were involved in the review of the information booklet and to ensure comprehensibility and usefulness to all involved. The first draft of the information booklet was completed and distributed to the participatory action group. The group was given the information booklet in both Maltese and English and it was agreed that each participant would give feedback directly to the research facilitator through individual communication within two weeks. This feedback was grouped into layout, content and grammatical issues which are presented in Table 5.4. This feedback and collaborative work conducted by this PAR group has enhanced the implementation of the information booklet into practice.

Table 5.4 Feedback given by the PAR group

Feedback on the information booklet by the PAR group		
Layout	Content	Grammatical
<ul style="list-style-type: none"> To rearrange the sequence of the occupational therapist role. To enlarge and change certain pictographs. To rearrange of sequence based on the patient journey. To amalgamate certain sections. 	<ul style="list-style-type: none"> To rephrase, add or delete words to sentences. To change or reword subtitles. To add more information on voluntary hospital services. To delete some sentences or paragraphs. To explain certain terms such as CT brain or ECG. 	<ul style="list-style-type: none"> To delete professional jargon and repetitive words. To arrange grammatical errors. To use consistently the same words throughout. To use easy to read language.

5.6.3 The implementation and evaluation of the information booklet

Phase 3 of this PAR Cycle involved the implementation and evaluation of the information booklet in clinical practice. The researcher did not recruit the same older patients and their ICs who had participated in Phase 1 for various reasons to include; mortality, limited mobility and pain. HCPs were the same throughout. Also, the researcher recognised that since the solution was a written information booklet, it was important to add an additional criteria for these participants to the existing list of eligibility criteria (Tables 5.2 & 5.3), that of literacy as given in (Table 5.5).

Table 5.5 Additional eligibility criteria for patients and ICs in Phase 3

Additional criteria of patients with fractured femur		
Inclusion criteria	Exclusion criteria	Rationale
In Phase 3, all stakeholders had to be literate in either Maltese or English.	Unable to read Maltese or English.	To evaluate the information booklet.

As in PAR, the problem could not be identified within any other research designs as one cannot plan the actions, beforehand. Moreover, it is fundamental in PAR to incorporate all stakeholders irrelevant of status, power and literacy level. Given that the solution to the identified concern was the development of an information booklet, the eligibility criteria for this phase had to be adjusted and only include literate participants in order to evaluate the booklet. One cannot exclude the fact that AR is a living process which is continuously developing and which cannot be predetermined but which changes and improves as those involved in it increase their understanding of the issues to be addressed and develop their capabilities as ‘co-inquiries both individually and collectively’ (Reason & Bradbury, 2006).

The research setting for this phase was similar to that of Phase 1 and the same working principles “relationships communication, participation and inclusion” Stringer (2014) were applied. A purposive sample of admitted older patients with a hip fracture and their ICs who met the eligibility criteria were approached on admission to the orthopaedic ward, by an intermediary ward nurse following ethical

approval for this evaluation. An information letter and consent form were given by an intermediary nurse to the participants either in Maltese or in English, according to their preference (Appendices 18A – 19B).

Prior to recruitment, the intermediary ward nurse was briefed by the researcher about the purpose of this phase. It was explained to the nurse that his role was to introduce the study to the patients and their ICs. Recruitment was conducted by the intermediary ward nurse to prevent coerced participation and the research facilitator approached only participants who accepted to participate. During the first meeting with the participants, the researcher reviewed the information letter, answered any questions the participants had whilst collecting the signed consent form.

The information booklet was evaluated during semi-structured interviews whereby another cohort of older patients (n=10) admitted to the orthopaedic ward together with their ICs (n=8) and who met the eligibility criteria were interviewed.

As mentioned above, the same HCPs contributed throughout the entire process of this PAR study. HCPs also had to sign a new information letter and consent form for this evaluation phase (Appendices 20A – 21B). Data was collected through two focus group discussions (n=8; n=6) to evaluate the booklet in practice.

5.6.4 Tools utilised for the evaluation of the information booklet

As with Phase 1, interviews were selected as a method of data collection over questionnaires or focus groups due to patient pain and limited mobility. It was considered that the participants may not feel confident to talk in larger groups whilst they would be more likely to communicate openly during a one-to-one interview (Koshy, Koshy & Waterman, 2011). Another **semi-structured interview guide** for patients and their ICs was developed. This guide was divided into sections to evaluate the information booklet and to determine whether it had helped in the care pathway from admission until discharge (Appendices 22A & B).

The **focus group interview guide** for HCPs also focused on its use in clinical practice and whether it had helped the HCPs to inform the patient better. The focus groups commenced with the research facilitator presenting two case scenarios to

recapitulate on the identified problem and solution, whilst giving an opportunity for every HCP to express his/her views (Appendices 23A & B).

To enhance self-expression in the interviews and focus groups, both guides were available in Maltese and in English. The accuracy of the translated versions was verified and confirmed by an expert in the Maltese language. When formulating these two interview guides, the same precautions as in Phase 1 were taken.

5.6.5 Pilot study

The interview guides were discussed with the orthopaedic PDN and the supervisory team. Minor modifications were made, such as adjustments to the sequence of the questions and rewording of a sentence. When a first draft is completed, the interview guide should be appraised by specialists in the area and by a linguistic person to identify spelling and grammatical errors (Polit & Beck, 2017). The first conducted interview with an older patient and his wife which took sixty minutes was used as a pilot study. Since this pilot interview went well and required no changes, the research facilitator continued with the data collection.

The first focus group with HCPs was regarded as the pilot study. The moderator was present and after the participants left, she and the researcher discussed whether any adjustments were required. The decision was that nothing needed to be changed and the researcher was able to continue with the data collection. Due to the success of this focus group, it was decided that the outcomes would form part of the data collection.

5.6.6 Data collection in Phase 3

The role of the researcher in collecting data through interviews and focus groups must involve being on time, polite, friendly and unbiased, show no dissatisfaction with responses and to assist participants to feel comfortable during the session (Patton, 2015; Polit & Beck, 2017).

5.6.6.1 Data collection from interviews with patients and their ICs

The distribution of the information booklet took place 2-5 days postoperatively. Semi-structured interviews were then held with the patients and their ICs. Interviews took place either at the acute or rehabilitation hospital or at the patient's house. The date, time and place were selected according to the older patient and his/her informal carers' availability. The length of time varied from the shortest, lasting thirty minutes and the longest lasting seventy minutes. All interviews were conducted in the Maltese language and were audio recorded and eventually transcribed verbatim to ensure a complete and accurate transcript (Gill *et al.* 2008b; Kisely & Kendall 2011). The interviews were later translated into English by a professional translator to enhance the process of data analysis and the presentation of the findings.

5.6.6.2 Data collection from focus group discussions with HCPs

Focus groups have gained the reputation as a means of gathering qualitative data (Sim, 1998; Freeman, 2006; Doody, Slevin & Taggart, 2013b). Feeling part of a group makes subjects more willing to enter in the discussion, thus more likely to make sense of an issue (Howatson-Jones, 2007). Conversely, the opposite may occur meaning that participants become anxious to talk in front of the group because they realise that their views are not in line with the rest and hence, do not speak to avoid negative comments. In this study, focus groups were conducted with HCPs due to the good collaborative working relationship which existed within this PAR group and during clinical practice. The researcher did, however, recognise that a focus group can present challenges especially with regards to the potential for bias (Mansell *et al.*, 2004).

Focus groups were regarded to be useful in this phase since they are frequently used in evaluation projects, can generate data related to collective views of a group of stakeholders, they enhance group interaction and present results to stakeholders and can clarify conflicting perceptions (Gill *et al.*, 2008a; Parahoo, 2014; Patton, 2015).

The optimal number for a focus group varies within the literature. Some suggest that a focus group should be composed of six to twelve people (Polit & Beck, 2017) whilst others limit the number to six to eight participants so that better control of the discussion is achieved by the moderator (Gill *et al.* 2008a; Kruger & Casey, 2000 as

cited in Doody, Slevin & Taggart 2013a). Two focus group discussions, with the first one being used as a pilot study, were conducted with various HCPs (n=8, n=6).

Focus groups were conducted at the local hospital. Participants were able to choose between two session dates, depending on their availability. Three weeks before the scheduled sessions, the HCPs were contacted directly and personally. The researcher explained, and this was reiterated in the written information letter, that although their participation was crucial for the evaluation of this information booklet, it was their right to withdraw at any time. She also explained that a high level of confidentiality was maintained throughout this study, including the group discussions.

Three days prior to the scheduled dates of the focus groups, participants were once again reminded about the time and venue so as to encourage a good response rate. The HCPs group was originally composed of seventeen participants, however the response rate was of fourteen HCPs since three were unable to attend either group even though they were conducted during lunchtime to help participation.

The research facilitator ensured that the environment was prepared for the focus groups by ensuring a comfortable environment which facilitates discussion and all participants were made aware of the process and what it entailed (Doody, Slevin & Taggart, 2013b; Patton, 2015). On introduction, participants were offered drinks and cakes to help them unwind from a busy morning. Following the fifteen minute refreshment break, the research facilitator reiterated what the purpose of the focus group discussion was. Since all members knew each other, the researcher as facilitator in this PAR introduced the presence of the local supervisor and her role as a moderator and explained the necessity of taking notes during the discussion. The moderator's role is to; listen actively, clarify ground rules at the beginning by explaining that only one member should talk at one time, select those who have not expressed their opinions as much as others and be able to pick up non-verbal cues (Doody, Slevin & Taggart, 2013b; Polit & Beck, 2017). All members were informed about the importance of keeping the conversation confidential and of allowing each other to speak.

The discussion continued with the evaluation and use of the information booklet. The focus groups were audio recorded and transcribed verbatim immediately after the discussion to enhance the accuracy of the information. There were no restrictions about the language and focus groups were spontaneously conducted in Maltese. However, there were times during the discussion when participants felt that they could express themselves better in English. Since all HCPs were bilingual, this did not cause any problems amongst participants. Following data saturation the first focus group ended after eighty minutes, whilst the second was completed after sixty minutes. A summary of the key points was presented to the participants at the end of each focus group.

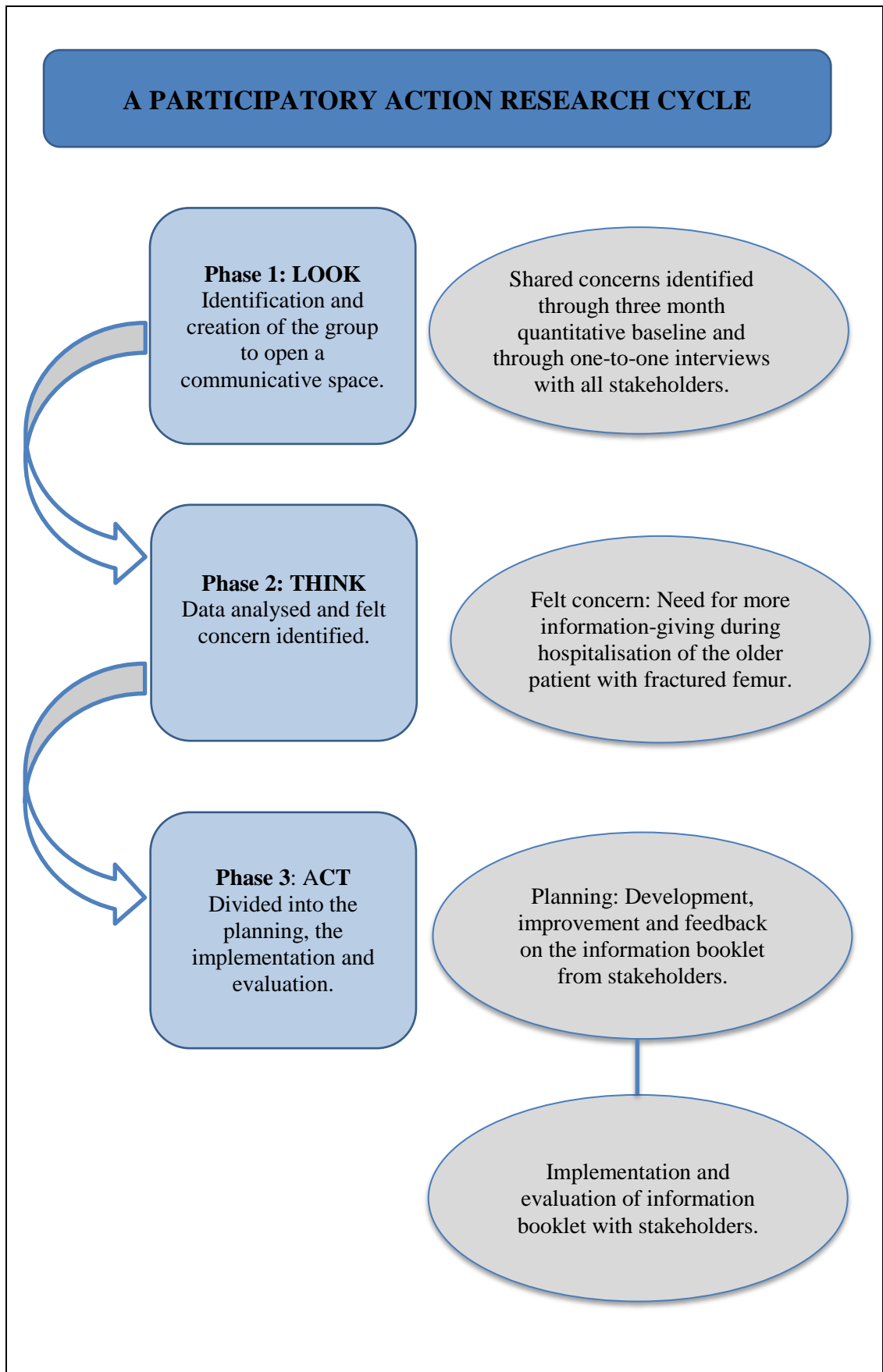
5.7 Overview of the PAR Cycle

This chapter described how the PAR process was developed and how it was guided by the Theory of Communicative Action (TCA) (Habermas, 1984). A PAR approach was selected over other traditional paradigms with the aim to improve the journey of the Maltese older patients with fractured femur. The researcher discussed how a public sphere was established and a communicative space was created to identify a felt concern.

This research followed three phases which incorporated **one action research routine cycle** of “LOOK, THINK and ACT” (Stringer, 2014, p.8). The Habermas (1984) Theory of Communicative Action was adopted to assist a group of stakeholders to open a communicative space to discuss felt concerns. They highlighted a need for more information-giving, whilst the older patient is hospitalised. The identified solution was the need for an information booklet which was developed, implemented and evaluated in practice by the research facilitator together with a group of stakeholders.

A summary of each phase as applied to this study and methods of data collection is presented in Figure 5.2. An overview of the implications of each phase is presented after the figure.

Figure 5.2 Process of a PAR Cycle in journey of older hip fracture patients



The PAR Cycle commenced with Phase 1 (LOOK) where all possible participants were included and through discussion between strategic action and communicative action provided participants with an opportunity to identify the problem. The researcher's role as a research facilitator was acknowledged. Data collection methods included semi-structured interviews and three month quantitative data to obtain demographic characteristics and care pathway of the target population.

The participatory action group in Phase 2 (THINK) of this PAR Cycle identified a consistent need for more information during the journey of the older patient with hip fracture. Phase 3 (ACT) is divided into the planning, implementation and evaluation of the information booklet. The information booklet was implemented in practice and was evaluated through interviews with older patients and ICs and focus groups with HCPs. Following data collection, the next step was data analysis to analyse the information which had been received.

5.8 Data Analytic Techniques

In this study, both quantitative and qualitative data was collected. The researcher studied various data analytic techniques relevant to both types of data.

5.8.1 Quantitative data analysis

The three month quantitative data analysis was processed by the Statistical Package for Social Sciences (SPSS), Version 22. The advantage of using this package (SPSS) was that it allows the researcher to score and analyse quantitative data very quickly and in different ways (Bryman & Cramer, 1999). Quantitative data were analysed through descriptive statistics which presented a summary of information about data (Greasley, 2008; Harris & Taylor, 2008). The descriptive statistical tests analysed data from fractured femur patients admitted to the orthopaedic trauma ward between May and July 2013. Demographic characteristics of data collected were coded into numbers and inputted into the SPSS database. This was conducted to obtain a view on the characteristics and pathways of the older fractured femur patients. Accuracy in data analysis and throughout this PAR Cycle was maintained constantly.

5.8.2 Qualitative data analysis

The purpose of qualitative data analysis is to sort data, to provide structure and to synthesize meaning from data (Polit & Beck, 2017). Data analysis can be the most challenging part throughout a research process (Clissett, 2008; Priest, Roberts & Woods, 2015). It is multifaceted as researchers often utilise too much time planning how to collect data whilst assigning insufficient time to analysing it (Jirwe, 2011). The lack of standardised procedures and absence of universal rules for analysing data makes it hard to explain how it should be carried out (Polit & Beck, 2017).

Data analysis either commences immediately or occurs throughout the first data collection and whilst this analysis process continues, it may shed light on subsequent data collection (Burnard *et al.*, 2008). In this study, all transcripts were assigned a code number and pseudonyms were chosen to protect the stakeholders' identity. As recommended by Stringer (2014), the analysis of each group of participants were analysed separately to identify different viewpoints and ways on how the journey of the older patient with hip fracture can be improved. This may help to understand commonalities and differences in group perspectives (Stringer, 2014).

There are no right methods to data analysis but it is acquired through practice (Froggatt *et al.*, 2001) and is an ongoing process throughout the entire project (Mauthner & Doucet, 2003). Although, guidelines exist in analysing qualitative data, there are no formulas for replicating the investigator analytical thought processes since this process is unique to each researcher (Patton, 2015). To commence with a robust qualitative data analysis, a framework to guide the phases of the analysis is required, especially if the researcher is novice (Smith & Firth, 2011).

Various frameworks exist. The Qualitative Analysis Guide of Leuven (QUAGOL), developed by Dierckx de Casterle *et al.* (2012) consists of two parts, each with five stages; the fourteen stage Thematic Content Analysis, developed by Burnard (1991) and the six phase Thematic Analysis Framework by Braun and Clarke (2006).

In this study, all qualitative data collected were analysed using the thematic analysis guided by Braun and Clarke (2006). This leads and assists in the process of data analysis, whilst it helps in identifying, analysing and reporting patterns known as

themes (Braun & Clarke, 2006). This thematic analysis framework was selected over the frameworks presented by Burnard (1991) and Dierckx de Casterle *et al.* (2012) since it is more flexible, straightforward and quick to learn and utilise (Braun & Clarke, 2006). It is considered beneficial for novice researchers with limited experience in qualitative analysis and provides essential skills which can be useful for conducting other forms of data analysis in the future (Braun & Clarke, 2006). It also did not bind the researcher with any theoretical commitments. Braun and Clarke (2006) recommend that this guide is a useful method for researchers adopting a participatory research with stakeholders as collaborators. It provided the researcher with the advantage of summarising key features of a large body of data presented in this PAR Cycle (Braun & Clarke, 2006). A detailed analysis of this process is given in Appendix 24, while an overview is given below.

Step One of this data analysis (Braun & Clarke, 2006) commenced with a **familiarisation of the data** whereby the researcher transcribed the data by listening to the recordings several times and typing what had been said. The transcripts were then imported into the computer software data analysis programme, NVIVO 11 which was selected since it efficiently manages large data sets when coding. It is also beneficial when searching and retrieving data and may assist in highlighting new levels of analysis (Gerbic & Stacey, 2005; McLafferty & Farley, 2006).

In **Step Two**, which involved **generating initial codes**, the researcher generated the initial codes from the raw data. Since this PAR study was to identify the problem with the stakeholders, coding and themes were dependent on the data obtained. Initial codes were matched with data excerpts that represented that code and the researcher ensured that all data excerpts were coded.

Step Three included **searching for themes** which requires the analyst to collect all codes into potential themes after all data was coded (Braun & Clarke 2006). The researcher sorted the different codes into potential themes and organised all relevant coded data extracts within the identified themes. This helped the researcher to think between codes and themes, whilst considering how different codes may combine to form an overarching theme. Some initial codes were clearly defined and organised under subthemes which were then collated into the main themes.

Step Four involved **two levels of reviewing and refining of themes**. Level One required the researcher to ‘review’ the collated extracts for each theme and when it appeared to form a coherent pattern, the researcher moved to the second level (Braun & Clarke, 2006). When the themes did not fit, the analyst had to rework the theme (Braun & Clarke, 2006). Level Two involved ‘refining’ the validity of the individual themes, in relation to the entire data. The researcher read the data set again to ensure that the themes ‘worked’ with the data set and coded any other data that had been overlooked earlier (Braun & Clarke, 2006).

Step Five involved **defining and naming the themes** which required the researcher to define and further refine the themes which were then presented for analysis (Braun & Clarke, 2006). This recognises the “essence of what each theme is about and determining what aspects of the data each theme captures” (Braun & Clarke, 2006, p.92). **Step Six** involved **producing the report** which provided the researcher with the final opportunity for analysis. She attempted to provide a succinct, comprehensible, logical and non-repetitive report which included participant excerpts for each theme (Braun & Clarke, 2006).

5.9 Principles of PAR in relation to this study

A set of working principles was adopted so as to obtain a PAR which incorporated good practice and skills. The researcher believes that this ameliorated collaboration between the stakeholders and applied these principles throughout the PAR Cycle. These principles (Stringer, 2014) indicate some of the notions that need to be considered in order to acquire truly effective outcomes to the multifaceted and deep-rooted problems that affect individuals’ lives.

These principles also enhanced the trustworthiness of the study and acted as a framework which eventually helped to enhance communicative action (Habermas, 1984) within the group and guided the research facilitator in participant recruitment. These principles based on Stringer (2014, p. 28) include; “**relationships, communication, participation and inclusion**” and are discussed in the next sections.

5.9.1 Relationships

When using PAR, it is generally necessary to eliminate status and power; use consensual modes of operation and participants should feel that their opinions are acknowledged whilst making a valuable contribution to the group (Stringer, 2014). In this study, all contributing stakeholders were made aware that their input was vital and that they were collaborators in the process through verbal communication. All participants were made to feel valued and were considered as equal members at all times. The researcher explained that their feedback was invaluable and contributed towards the improvement of the provision of quality care for future older hip fracture patients. This was clearly stated prior to the recruitment of each participant that the role of the researcher was of a facilitator and colleague.

To decrease the impact of power due to the dual role of the researcher (charge nurse and research facilitator), all patients' and Informal Carers' (ICs) interviews were conducted outside the hospital environment so that older patients and their ICs felt more comfortable and at ease in the environment. Preventing disruptions during interviews whilst giving the participants the opportunity to talk was achieved by providing a relaxed and private environment (McCann & Clark, 2005). Dearnley (2005) recommended that the location of the interview should offer privacy and decrease the hierarchical status that might influence the interaction; the researcher must even consider how s/he is dressed since formal clothes may cause a barrier.

5.9.2 Communication

Positive change is the product of communicative action that keeps people working efficiently together (Habermas, 1979, as cited by Stringer, 2014). For communication to be effective, the three validity claims (truth, rightness and truthfulness) were consistently abided by throughout this PAR.

The researcher ensured that all communication was clear and the use of jargon was avoided in the information letters, in the consent form and during data collection and feedback. The research facilitator constantly asked if the participants required any clarification and kept informing the group what was happening. During the focus groups with HCPs, all collaborators were given an equal chance and opportunity to speak, irrelevant of their professional ro

5.9.3 Participation

This was maintained by having minimal eligibility criteria so as not to exclude any group of participants whether they were patients, their ICs and HCPs. Stringer (2014) asserts that participation in AR is successful when it deals with the right contributors, rather than with their representatives. Recruiting older hip fracture patients, rather than just their ICs or HCPs, enhanced equal participation and allowed older patients to voice their concerns. The research facilitator believed that these patients were an important group and they were able to identify their problems and suggest possible solutions as did the other key stakeholders.

5.9.4 Inclusion

The research facilitator ensured that all possible participants were included in the whole process at all times. This study did not include higher administrative representatives so there was no undue influence exerted on any of the participants. Although one of the researcher facilitator's roles is managerial, it was made clear to the stakeholders that the purpose of this collaborative work was the improvement of the journey of older fractured femur persons.

In Phase 1 of the PAR, older hip fracture patients were included whether they were literate or not, since their participation was deemed to be important. The research facilitator did not believe that the level of education or knowledge should exert any influence on the recruitment of the sample. This also applied to the recruitment of HCPs and included various categories of professionals, from nursing aides to orthopaedic surgeons and consultants. Stringer (2014) asserts that the concentration of control and participation in organisational healthcare agencies is represented by the middle class groups whilst the concerns of the dependent, their needs and agendas remain unheard. The researcher's role in PAR involved continuously ensuring that the above working principles are synchronised with every procedure and that all actions promote participation amongst stakeholders is the researcher's role at every stage in his/her work (Stringer, 2014). These working principles were vital for this PAR since they enhanced the study's trustworthiness.

The researcher's role as a research facilitator is different from that of the traditional researcher. Prior to the commencement of this study, the researcher was an outsider

to the research setting. In October 2012, she was given the role of charge nurse. This change helped the researcher to become an insider to the research setting. Holian and Coghlan (2013) defined 'insider action research' as when an individual member of an organisation takes an explicit AR role, together with the usual functional roles they have within the organisation. They pointed out that the advantage of an insider researcher is that the research is centred on the process and is conducted by a researcher who is a member of the organisation rather than joining only for the duration of the study (Holian & Coghlan, 2013). Therefore, this eliminated problems which might have emerged if the researcher was perceived especially by the HCPs as an intruder or as an inquisitive stranger trying to impose an agenda (Stringer, 2014).

Being an insider helped throughout the whole process and offered a better understanding of participants and the ward environment. The researcher's role in this PAR study was therefore that of a research facilitator participating in the entire research process. With regard to HCPs, the researcher was aware that since they were all colleagues, her position as a charge nurse could have also been perceived as 'threatening' to them (Lincoln & Guba, 1985). This was neutralised by reminding all participants about their right to refuse or withdraw from this PAR study without any explanation. This enhanced honesty and genuine readiness in their participation.

5.10 Building research rapport in insider action research

Reason and Bradbury (2008, p.286) explain that when individuals work together and see the impact of communication amongst people, processes and ideas, "they obtain a deeper sense of empathy, a broader organisational mind-set and a better understanding of how to collaborate with others to get things done." While engaging participants in this PAR Cycle, the research facilitator ensured that a clear aim of the study to all stakeholders was communicated. All participants were provided with a well-defined vision from the commencement of this study which was the improvement of the patient care pathway and it was demonstrated that everyone's participation was vital, irrelevant of whether they were a patient, an IC or HCP. This helped to increase trust and led to the research facilitator and the participatory action group to openly communicate and demonstrate the integrity of the study.

The engagement process commenced by giving introductory material which contained an information letter and consent form. Additionally, in the 'Think' Phase the research facilitator invited patients to participate just before their discharge and not before. In the 'Act' Phase, she gave an introductory session to an intermediary ward nurse on how to invite the older patients and their ICs. The intention of this was to prevent coerced participation. As a charge nurse, the research facilitator was not involved with direct patient care since she holds a managerial role. She hopes that this also prevented patients from feeling under any pressure to participate.

Another issue which helped stakeholders to engage in this study was that at the beginning of each interview, each participant was invited to talk about their daily life prior to the fracture. HCPs were also invited to talk about their role in the care of an older patient with a fractured femur. This brief introduction helped to reduce any communication barriers from the start and offered participants the opportunity to explore their own thoughts in a safe one-to-one dialogue. On the other hand, the fact that the research facilitator was an insider to the research context may have influenced participation by unknowingly being judgemental or by being perceived as an intruder by the participants. However, all participants were provided with continuous feedback with regular updates into the emerging study findings. Besides, the one-to-one continuous two way communication and feedback sessions influenced and motivated the stakeholders to take part in the participatory action group which led the study towards the 'Act' Phase (development, implementation and evaluation of the information booklet).

The communication the researcher held with the older patients and their ICs, empowered them to participate since they would not have been represented if traditional research methods had been utilised. By participating and engaging in this study, participants were given a voice which influenced the PAR Cycle which in turn, would actively bring about sustainable improvements in the care pathway of older fractured femur patients. Moreover, the fact that participants were invited prior to their discharge left them free to decide about their participation. Regarding HCPs engagement, they acknowledged the researcher's philosophical stance which was based on equity, communication and on decreasing the paternalistic effects the hospital system may have on these older patients.

Even though a good working relationship existed prior to the commencement of this study, a professional research rapport was also established with the HCPs. In her managerial role as a Charge Nurse, the researcher further strengthened her working relationship with her colleagues by being positive, by praising their work, by listening attentively and helping them with their needs. She regularly allocated time to discuss their concerns and made sure that time was regularly scheduled for team building activities. The researcher believes that a positive rapport was established within the ward environment and was demonstrated by all HCPs who immediately agreed to participate in this PAR study and persevered with the group until the end of it. The stakeholders continuously showed genuine support throughout this journey.

It must be said that the researcher's position as a manager within the ward could have created power issues. Thus to avoid this, she made sure that no authoritarian decisions were taken with the HCPs and all interviews were conducted outside working hours to try and minimise bias as much as possible. With regards to HCPs, the researcher's position as a manager was only remarkable with the nurses' sample. Since the researcher was not in charge of other team members, such as doctors, physiotherapists, OTs, social workers, the rehabilitation nurse or the community nurse, there was little possibility of any coercion on any other HCPs to engage in this PAR Cycle. Furthermore, it was important and was made very clear, that the researcher's role as a charge nurse was not to judge or examine their role proficiency or professional practice, but to gather information on how the fractured femur patient care pathway could be improved.

All the participants realised and agreed that this study was something which could make their jobs more satisfying. Moreover, the relationship the researcher has with nurses, both professionally and personally, was considered as an asset to obtain the most realistic view and enhance the trustworthiness of this study. Being an insider could have been a disadvantage throughout the process but all precautions were taken so that this did not exert any coercion on the participants. Conversely, it definitely helped to enhance the trustworthiness of the study due to a better understanding of both the participants and the environment.

5.11 Enhancing the quality of the study

In the 1980s, action researchers attempted to use quantitative criteria for assessing rigour. However, they subsequently adopted the parallel criteria of qualitative work (Koch & Kralik, 2006). Rigour in AR is grounded on checks that ensure that researchers have meticulously established the “veracity, truthfulness or validity of the information and analysis that have emerged from the process” (Stringer 2014, p.92). Cautious attention to establish trustworthiness determines the credibility of the findings and interpretations (Patton, 2015).

Extensive literature exists on the debate about the criteria required to assess the quality of qualitative research. Rolfe (2006) identifies three debatable issues namely that there are researchers who want to judge the natural phenomena using the same criteria as the quantitative researchers use; there are others who consider that other criteria is required; whilst still others question the suitability of any predetermined criteria for reviewing qualitative research. An important issue in qualitative data is reflexivity which enhances trustworthiness of the study.

5.11.1 Reflexivity

Reflecting critically on the actions and behaviours in relation to the stakeholders and the research process denotes reflexivity (Williamson, Bellman & Webster, 2012). Reflexivity is a useful tool in understanding more clearly the meanings of the phenomenon being studied (Carolan, 2003). To prevent personal bias and judgement throughout the entire PAR Cycle, the research facilitator took precautions to maintain an impartial position without exerting any influence on stakeholders. The following considerations were taken:

- At the beginning and throughout the entire PAR process, the research facilitator acknowledged her dual role as a researcher and as an insider to the research setting and context.
- Reflexivity in this study was established by continuously evaluating each action in ensuring that no influence was executed on the stakeholders.

- Reflective accounts using John's Model (1995) and note-taking following supervision discussions were utilised to guide the research facilitator to reflect in detail throughout these accounts.
- The research facilitator tried to be fair throughout the entire process with special considerations taken whilst recruiting participants until the end of this PAR Cycle.
- The notion of empowerment and that all participants were regarded equal with respect to the study was made clear. The research facilitator role as being part of the group was emphasized to enhance trust between the interviewer and the interviewee.

5.11.2 Trustworthiness in qualitative data

In this study, 'trustworthiness' is explained by the most commonly used criteria by qualitative researchers proposed by Lincoln and Guba (1985). They explain four measures in maintaining trustworthiness of qualitative data including; credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985). A fifth criterion, 'authenticity' was included with this criteria following criticism and the authors' own progressive conceptualisations (Patton, 2015; Polit & Beck, 2017).

Credibility refers to the confidence in the truth of the data and representation of them by the researcher (Polit & Beck, 2017) and the four principles mentioned previously in Section 5.9 were applied. Prolonged engagement was maintained by the researcher being present during the whole PAR Cycle in order to build trust and rapport with stakeholders. As charge nurse of the ward, the researcher is accustomed to visiting the patients to observe and discuss any issues of concern with them. This enhanced the researcher's ability to communicate with the participants.

Patton (2015) states that, time utilised at interviewing, at the research site and time for building rapport with participants all contribute to trustworthy information. A reflective account, which includes further observations on the admission and

discharge process (journey of older hip fracture patients), was completed by the researcher (Appendix 25).

Triangulation was achieved when multiple sources of information were obtained (Long & Johnson, 2000; Stringer, 2014) and has been utilised to prove confirmability (Tobin & Begley, 2004). In this PAR, data source triangulation was achieved by including all stakeholders involved in the journey of older hip fracture patients in order to add more richness to the description and provide verification of the shared concern. Collecting data from older patients, ICs and all the members of the MDT helped to achieve the aim of validating data through multiple perspectives on the phenomenon (Polit & Beck, 2004). In this study, method triangulation was achieved by collecting data through various means, namely three month quantitative data collection, semi-structured interviews with participants and focus groups.

A method used to enhance peer debriefing involved organising meetings between the research facilitator and her peer who is skilled in the methods of qualitative inquiry or on the topic being studied or both (Polit & Beck, 2004). In this study, three transcripts were given from each group (Phase 1 and 3) together with the analysed data to a Practice Development Nurse (PDN) for peer evaluation, who is skilled in qualitative research methods. Whilst this colleague was not an official research expert, her nursing education, background and experience helped in validating the trustworthiness of these findings. A sample of transcribed interviews from each group of participants from Phase 1 (n=9) and Phase 3 (n=3) were also analysed by the orthopaedic PDN. The research facilitator, together with the orthopaedic PDN who is an expert on the subject and had experience with qualitative data analysis, met and discussed the emerging themes on various occasions. To ensure accuracy of data, after transcription of all interviews, all HCP participants plus two patients and their ICs were shown the transcripts for their evaluation and confirmation that the transcripts were a true representation of the interviews.

Member checks are vital and considered as one of the important procedures for establishing credibility (Cope, 2014). Member checking was achieved in this PAR since all HCPs were provided with feedback regarding the emerging themes and interpretations about all the collected data. Furthermore, since at the end of each

focus group, the research facilitator summarised the points which had been discussed and an opportunity for final questions and remarks was offered. Minimal information was added at this point. Highlighting the most important points was useful for confirmation or explanation of the main issues by the group (Gerrish & Lacey, 2010). The principle of inclusion ensures that all stakeholders are involved in the study which enhances the credibility of the entire process (Stringer, 2014).

Dependability refers to the “stability of data over time and conditions” (Polit & Beck, 2017, p.599). It is the degree to which people can have confidence in the followed systematic research process. To ascertain dependability, the research facilitator abided by the audio-recordings for accurate data analysis. This was maintained by presentation of the work to the supervisory team. Furthermore, detailed notes on this PAR study were kept on the discussions held and decisions taken between the researcher and the supervisory team had enhanced the study’s reliability (Roberts, Priest & Traynor, 2006).

Another criterion was that of **confirmability** which denotes that the data is neutral (Polit & Beck, 2017). Being an insider, the research facilitator could be criticised as introducing subjectivity. Various precautions were taken to keep neutral throughout the entire process. Confirmability was enhanced by including detailed excerpts in the findings that supported each emerging theme (Cope, 2014). Moreover, participants were given the option to discuss concerns either in Maltese or in English to enhance communication and gave them the option to speak freely.

Although translations were performed by a qualified translator, a random sample of two interview transcripts was back translated by Maltese and English lecturers in the respective languages. Discussions between the research facilitator and these two linguistic professionals were conducted to remove any discrepancies in the language. For the translation of the information booklet and other translations, reference was made to two books entitled *Medical Language Translator* compiled by Cachia (2013) and *The Malta Medical Students Association and the Kelmet il-Malti Dictionary* by Bugeja (1999).

Transferability refers to the degree to which the results can be transferred or are applicable to other groups, often referred to as generalisability of the findings (Polit

& Beck, 2017). Although generalisation of the findings is not the goal of AR as in quantitative studies, AR outcomes are applicable only to those particular people and setting that were part of the study (Badger, 2000; Stringer, 2014). The researcher has the responsibility of accurate reporting and of providing sufficient information so that the reader can decide upon the applicability of the study (Lincoln & Guba, 1985). To enhance transferability, a detailed description of the process of this PAR Cycle together with data collection methods, data analysis and the findings were presented accurately within this dissertation. ‘Thick description’ of the phenomena under study in this PAR and the context in which the study was conducted could be viewed as a skill for enabling transferability decisions. The notion of whether the data is transferable must be considered in the light that this PAR study was focused on improving the journey of the older hip fracture patient rather than presenting findings which may be transferable to other contexts. The fact that it is an action research focused towards improvement does not shift the researcher’s responsibility towards quality. Hence, transferability was left up to the reader to consider its applicability whilst taking into consideration the cultural influences as well.

Authenticity denotes the degree to which researchers justly and faithfully demonstrate reality (Polit & Beck, 2017). When a study achieves authenticity, the readers are more capable to comprehend the lives being described in a complete way with some sense of the mood, feelings, experience and context of those lives (Polit & Beck, 2017). To achieve this criterion in this study, detailed explanations of the stakeholders’ felt concerns and experiences were given, prompting the reader to better understand the older patients’ journey whilst being hospitalised. Being honest throughout this PAR helped all stakeholders act ethically at all times.

5.12 Ethical Issues

The researcher should promote ethical practice and be committed to an ethical approach (Bowling, 2011). The well-being of each participant took precedence over all other interests throughout this study (Declaration of Helsinki, 2013).

5.12.1 Ethical principles underpinning this PAR

As researchers in clinical practice, there is a responsibility to avoid or decrease harm to all patients who engage in research studies (Stringer, 2014; Polit & Beck, 2017) whilst ethical guidelines must be strictly followed (Koshy, Koshy & Waterman, 2011). Since the researcher is an insider to the study environment, various ethical issues were considered and discussed below. Ethical notions in organisational insider AR vary from other AR because of the researcher's role duality, including the continuous work role and the role of action researcher (Holian & Coghlan, 2013). The researcher ensured that no pressure was exerted upon any participant throughout PAR research study and it was guided by a set of ethical principles (Table 5.6).

Table 5.6 Ethical principles guiding this PAR

Ethical principles
1. Prevention of harm
2. Informed consent
3. Maintaining confidentiality and anonymity
4. Honesty and integrity
5. Withdrawing from the action research
6. Research approval and guidelines

Source: Winter & Munn-Giddings (2001); Williamson, Bellman & Webster (2012)

Prevention of harm: The duty to protect participants who act as co-researchers in an AR is fundamental to action researchers (Coghlan & Brannick, 2010). In order to prevent the situation where older patients and their ICs feel coerced to participate, various measures were implemented. In Phase 1, participants were recruited prior to discharge, so that older patients did not feel coerced or feel that their decision of not

participating might have had an effect on the quality of care or that the nurse-patient relationship was being exploited (Polit & Beck, 2017).

In Phase 3, an intermediary nurse who was not participating in this study invited participants and was engaged in recruitment to prevent patient coercion because of the researcher role duality. The researcher only approached participants once they confirmed their participation to the intermediary nurse.

Similar principles were applied for the recruitment of HCPs for the interviews and focus groups and consent was obtained by the researcher following a verbal explanation of the study aim. The researcher emphasized to all participants that if should they accept, it would be on a voluntary basis. Consequently, they were given time to decide, to read the information letter and the consent form. The above precautions were taken to ensure that collaborative working, the change process and outcomes were not hindered by the researcher's need for academic accomplishment (Williamson, Bellman & Webster, 2012).

Informed Consent: Another ethical issue encountered by action researchers, is the constant change of direction of the research as action is continually informed by the findings whereby change needs further ethical considerations (Koshy, Koshy & Waterman, 2011). Holian and Coghlan (2013) explain that various insider AR may be considered as low risk because it involves activities that are part of normal business within the organisation. However, because of the above discussed notions in relation to the changing nature of AR and consent form, the researcher applied for two ethical permissions.

Informed consent was obtained after ensuring that all participants understood the given information. To enhance understanding, the information letter was offered in both languages and was also supported by a verbal explanation and time for questions given. In Phase 1, older hip fracture patients and their ICs who were unable to read were given the opportunity to have someone read the information letter to them. In both phases, the patient information sheet and consent form were designed keeping in mind participant age who might have had difficulties with

vision. A large font style and size fourteen was used to ensure readability. Jargon was avoided so that the information given was easily understood.

Maintaining confidentiality and anonymity: It is the participants' right that confidence be strictly maintained during data collection (Polit & Beck, 2017). Although anonymity was not possible in the interviews and focus groups, information was kept confidential by not revealing any names. On commencement of the focus groups, it was emphasized that all information shared between collaborators must be kept confidential. It is essential in AR to negotiate the rules of confidentiality which are satisfactory to participants and all decide to approve accountability (Winter & Munn-Giddings, 2001; Koshy, Koshy & Waterman, 2011).

Code numbers replacing participant names should be used and information should be kept secure (Koshy, Koshy & Waterman, 2011). Confidentiality was maintained in this PAR by keeping participants' confidential at all times (Williamson, Bellman & Webster, 2012). In fact, during the interviews, whenever an individual or professional working in the orthopaedic ward was referred to by their name, this was replaced by a fictitious name to prevent identification.

Each participant was assigned a code number and pseudonym to each participant which is only known to the researcher. The list identifies each participant to his/her respective research code, interview transcripts and other identifying information, such as audio recordings, were kept on a password-protected computer accessed only by the researcher. These lists, backup data and the recorder were stored under lock and key and will eventually be erased upon completion of this study.

Regarding recordings, permission was requested from all participants. Notes would have been taken instead if there were objections which was not the case. Simple notes were still taken by the researcher during the interviews. A declaration on the protection of audio recordings was signed by the researcher with the Data Protection Unit of the local hospital (Appendices 26A & B). It confirmed that only the researcher would have access to these recordings and that they would not be replicated or uploaded in any server or any other media. Also, the researcher declared that the study was guided by the Data Protection Act (2003).

Honesty and integrity: Throughout this study, participants were informed that the study would not provide a solution or offer answers to all the difficulties encountered during the patient's care pathway. It was explained that it is a learning process for all involved (Williamson, Bellman & Webster, 2012). The researcher ensured that all participants' views were voiced and all findings were reported. All participants were constantly briefed about previous findings before each interview or focus group to ensure that the research development is transparent to all (Stringer, 2014).

Withdrawing from the action research: Participants have the right to ask questions, refuse to participate, ask for clarification or stop from participating whenever they wish (Holian & Coghlan, 2013; Polit & Beck 2017). The researcher ensured them that if they refused to participate or they withdrew from the study, their decision would not have any effect on the quality of care.

Participants were constantly informed about their right to withdraw, even though their withdrawal could have caused difficulties for this study. For instance, their lack of input in the first AR cycle could have put at risk the development of the information booklet which was implemented in practice in the second AR cycle. Koshy, Koshy and Waterman (2011) explained that when an AR is aimed at improving practice, it is very unlikely that participants refuse to take part.

Researchers conducting qualitative research studies are faced with issues of bioethics, being a researcher, therapist or nurse, and being human (Haahr, Norlyk & Hall, 2014). This was evident during an interview in Phase 1 with an older patient, whereby the researcher decided to discontinue the interview because of ethical reasons. Her non-verbal communication demonstrated that she was in pain and she seemed to be losing her concentration and was limited in her communication.

Research approval and guidelines: The researcher sought ethical approval before commencing the PAR Cycle. This study protocol was guided by the ethical guidelines of the University of South Wales, U.K, the University of Malta, the principles of the Declaration of Helsinki (2013), the Maltese Code of Ethics for Nurses and Midwives (1997) and the Data Protection Act (2003).

Research approval for this PAR study was sought and granted from the Faculty Ethics Committee of the University of South Wales U.K. and the University of Malta Research Ethics Committee (Appendices 27 & 28). For the two phases, local institutional permissions (Appendices 29 & 30) were also granted (Tables 5.7 and 5.8).

Table 5.7 Institutional permissions for the PAR Cycle in Phase 1

<p>In PAR Cycle Phase 1 permissions were granted from the following:</p> <ul style="list-style-type: none">• Medical superintendent and the Chief Executive Officer of the acute hospital, Chairperson of the Orthopaedics department, Senior in charge of the Physiotherapy and Occupational therapy department and the Social workers department.• Director of Nursing Services in the acute hospital, rehabilitation hospital and from the Chairperson of the Geriatric Services.• Director of Primary Health Care, Director of Nursing Services and Nursing Officer at the CommCare assessment unit.• Data Protection Officer.• Research Ethics Committees from the former University of Glamorgan, Wales and Research University of Malta (2012).
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Table 5.8 Institutional permissions for the PAR Cycle in Phase 3

<p>In PAR Cycle Phase 3 permissions were granted from the following:</p> <ul style="list-style-type: none">• Chief Executive Officer of the acute hospital, Chairperson of the Orthopaedics department and all Orthopaedic consultants.• Director Nursing and Midwifery Services and Senior Nursing Manager in the acute hospital setting.• Information management and technology directorate (data protection unit).• Research Ethics Committees of the University of South Wales, U.K and University of Malta (2016).

5.13 Conclusion

A PAR design was selected using a basic action research routine cycle (LOOK, THINK and ACT) as outlined by Stringer (2014). The cycle consisted of three phases to enhance the journey of the Maltese older patients admitted unexpectedly to hospital with fractured femur. The Habermas (1984) Theory of Communicative Action assisted a group of stakeholders to open a communicative space to identify a felt concern. The need for more information-giving was highlighted whereby the identified solution was the need for an information booklet. During this PAR cycle a booklet was developed, implemented and evaluated in practice by the research facilitator together with a group of stakeholders. The researcher's role as a research facilitator was acknowledged.

Methods of data collection in phase one (LOOK) included semi-structured interviews and three month quantitative data to obtain demographic characteristics and to explore the stakeholders' views on the care pathway for the older fractured femur patient from admission to discharge into the community. During communication with a participatory action group in Phase Two (THINK) of this cycle a consistent need for more information during the journey of the older patient with hip fracture was identified. Following the development of the information booklet data was collected in phase three (ACT) through interviews with older patients, their ICs and focus groups with HCPs. Data was analysed using the six step thematic analysis framework by Braun and Clarke (2006).

The ethical issues that emerged in this study were discussed and a set of principles by Winter and Munn-Giddings (2001) and Williamson, Bellman and Webster (2012) helped the research facilitator to address and clarify any ethical concerns. The trustworthiness in this PAR study was ensured by utilising Lincoln and Guba's (1985) criteria. The next chapter will outline the salient findings resulting from this research study.

CHAPTER 6

FINDINGS OF THE PAR CYCLE

6.1 Introduction

This chapter presents the findings of this Participatory Action Research (PAR) Cycle. The aim was to identify a shared concern, which was lack of information-giving and it was determined that the creation and distribution of the information booklet would eventually enhance the patient's journey from admission until discharge and beyond. This was achieved in various ways. In this chapter, a brief description on the participants' reaction to the PAR cycle was highlighted and quantitative descriptive information is presented to provide baseline data in relation to fractured femur patients admitted to the trauma orthopaedic ward at the acute hospital in Malta.

Stakeholders in this PAR Cycle included older fractured femur patients, their Informal Carers (ICs) as well as Health Care Professionals (HCPs) in the field. This study explored the stakeholders' views on the patients' care pathway together with their perceptions about the current discharge process, as well as on intermediate care. The sample was chosen purposely to encompass all possible stakeholders and to include both genders.

6.1.1 Participants' reaction to the PAR

During this PAR Cycle, many participants expressed how they wished to give their utmost to this study. They explained that this was because they were very conscious of the importance of this subject to their working experience. The researcher explained to them that there were no wrong answers and that all their perceptions and input were important and that what they discussed was useful. The researcher emphasised the importance of being honest. Patients were informed that if there were problems with the patient care pathway and these issues were not discussed, there could be no change or improvement in the care pathway of other older patients with a fractured femur. All participants, including the HCPs, accepted to participate

immediately. Medical people were also involved and all orthopaedic consultants in the ward agreed, signed the consent and approved the study. All HCPs and consultants in the orthopaedic speciality were aware that the study was being conducted in the ward.

Throughout the mini-cycles, the patients and their ICs were encouraged to express their needs and desires without any restrictions. They felt free to talk and express their worries. To illustrate this, ICs talked openly about visiting hours, hospital transport, waiting time at the emergency department, postponement of surgery and the long waiting time for discharge papers. Their voices were heard and were discussed with the participatory action group. They felt free to talk about everything related to the patient care pathway and they constructively criticised the study ward.

Additionally, various issues were discussed during this PAR Cycle and the patients and ICs mainly discussed the need for more information for more involvement in decision-making and communication issues. Besides, patients and ICs in the 'Look' Phase discussed the need for fall prevention campaigns, maintaining that if they had been more informed they could have prevented their fall. They voiced their concerns about the lack of information regarding the transfer to the rehabilitation hospital or their discharge home. All participants expressed their opinions freely, since they wanted other patients and their ICs to have a better hospital experience. Their participation was positive since most of the interviewees kept their appointment with the researcher and some of them in Phase 1, the 'Look' Phase, persevered for the second interview. All this resulted in a positive feedback for this PAR Cycle.

With regard to HCPs during the focus groups, each participant was encouraged to discuss, question and constructively criticise any statement brought up by anyone. During these focus group sessions everyone felt equal and nobody felt superior or in a position of power over another, given that there were various professionals starting from consultants to nursing assistants. Everyone was included in the dialogue and while it was noted that HCPs knew each other, a good working relationship existed between the whole multidisciplinary team. The researcher felt that HCPs looked forward to the focus group session since it was something being conducted for the first time in the ward.

During the 'Think' Phase, HCPs discussed person-centred support for individual patients and their families and that the one size fits all approach is not recommended. Most HCPs discussed that there was a need to get the basics right first and that relatives should be signposted about the available resources prior discharge. Consequently, people should be asked about their particular needs and should be continuously involved throughout the process to achieve the best possible outcome. This revealed that this could be achieved through the provision of regular information and communication.

On the other hand, patients in this phase stated that they should take the initiative to involve themselves. The researcher's reflections following the discussion with these patients were that she realised that patients and ICs should be self-agents of their care. This was also discussed with an OT who argues that some patients do not do their utmost to regain their independence. Conversely, on second thoughts, the researcher recognised that she should not be judgemental towards patients since each patient is a holistic individual patient with varying capabilities to take care of his/her own health.

Patients and their ICs also discussed simple things which were annoying to them whilst for the nurses these were trivial. For instance, patients talked about how some HCPs did not sufficiently explain new medications and what their side-effects could be. This showed that what is considered a simple matter for the HCPs was perceived as problematic by the patients and their ICs. On the other hand, the nurse and the doctor reiterated that some ICs immediately on admission decide and affirm that the patient is for long term care without letting patients discuss their future.

All participants showed their enthusiasm and responded positively throughout the PAR Cycle since they clearly considered the whole process useful to improving the service offered on the ward. The researcher determined this through the general comments made to her verbally from various participants, by noting the amount of feedback received during the development of the booklet and by the various recommendations received from the participants.

The HCPs' voice showed that although the physical part is vital, one cannot ignore the psychological aspect since it is important when it comes to regaining independence. Participants in the group also discussed the importance of involving ICs in the discharge planning process. They identified the need for early discharge planning and the importance of discharge planning to occur as early as on admission.

In addition, patients and ICs in this PAR participated enthusiastically by continuously giving feedback on the development of the information booklet constructed on their informational needs. The feedback received by all stakeholders during this stage was valuable as the information booklet was based upon family needs once an older patient is admitted to hospital. It was formulated to guide all stakeholders during the care pathway and their voices helped to question clinical practice.

6.1.2 Overview of data collection throughout this PAR study

As mentioned previously, during **Phase 1 (LOOK Phase)** a three-month quantitative study period was selected to obtain baseline data. Semi-structured interviews with all stakeholders were organised to determine stakeholders' perceptions on the care pathway.

Phase 2 (THINK Phase) included informal communication with these stakeholders which led to the decision to create an information booklet for older fractured femur patients. This was then implemented and evaluated in **Phase 3 (ACT Phase)**. During this final phase, semi-structured interviews and focus groups involving stakeholders were organised to evaluate the effectiveness of the information booklet.

Table 6.1 provides an overview of the data collection throughout this PAR Cycle.

Table 6.1 Overview of data collection throughout this PAR study⁴

PAR Cycle	Type of data	Stakeholders	Method of data collection	Number of participants	Time of collection
Phase 1	LOOK Phase Part 1: Three-month quantitative data	Patients with fractured femur	Records for 3 months	(n=61)	Admissions between May –July 2013
	LOOK Phase Part 2: Interviews with patients and their ICs.	Patients with fractured femur	One-to-one semi-structured interviews	16 approached, 1 interview discontinued	April 2013 – March 2015
		ICs		12 accepted, 1 without IC, 2 cannot be reached, 1 discontinued	
LOOK Phase Part 3: Interviews HCPs.	HCPs	HCPs (n=17)			
Phase 2	THINK Phase: Informal correspondence	Participatory Action Group (PAG)	Informal discussion	PAG: Patients (n=2) ICs (n=2) HCPs (n=8)	Various times during 2014 and 2015.
Phase 3	ACT Phase Part 1: Interviews	Paired older fractured femur patients and ICs.	Semi-structured interviews	10 patients and ICs approached, 2 ICs did not turn up for interview.	October 2016 – December 2016
	ACT Phase Part 2: Focus groups	HCPs	Focus group	2 repeated groups (n=8, n=6)	November 2016

In the following sections, the information gathered from Phase 1 and Phase 3 are presented in themes and subthemes. Reference is then made to relevant excerpts from the original transcripts to enhance the trustworthiness of the study and to analyse overall findings.

⁴Source: Koshy, Koshy & Waterman (2011).

6.2 Phase 1: LOOK Phase – Part 1

6.2.1 Description of quantitative data collection study

The three-month quantitative data collection study was conducted between May and July 2013 and involved sixty one patients who had been admitted to the orthopaedic ward with a fractured femur during that period. The admissions records were analysed and frequency tests were carried out.

6.2.2 Results

This section presents the findings of the three-month data collection study. The data collected from these descriptive statistical tests was then analysed according to gender (Figure 6.1), age (Figure 6.2), admission origin (Figure 6.3), length of stay (Figure 6.4) and patient discharge destination (Figure 6.5).

Figure 6.1 Gender of patients admitted with fractured femur

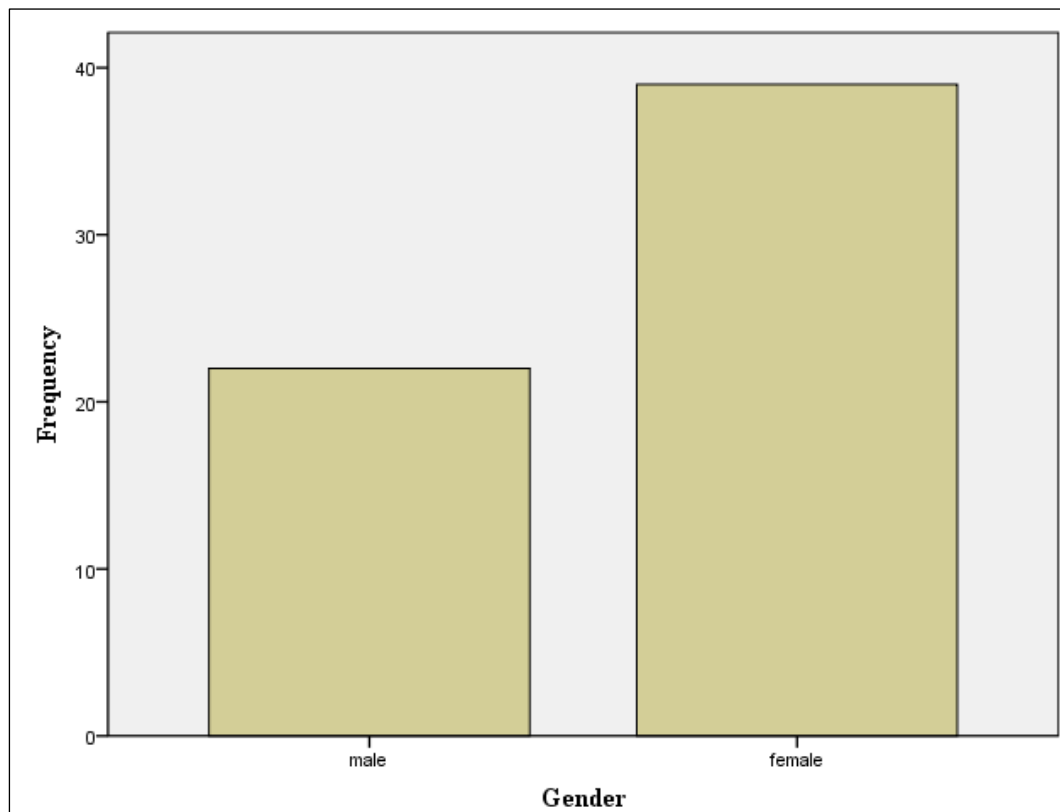


Figure 6.1 illustrates the gender of patient admissions during the three-month period. Out of a total number of patient admissions, (n=61) male patients comprised 36.1% (n=22) of total admissions while female admissions represented 63.9% (n=39).

Figure 6.2 Age of patients admitted within the three month period

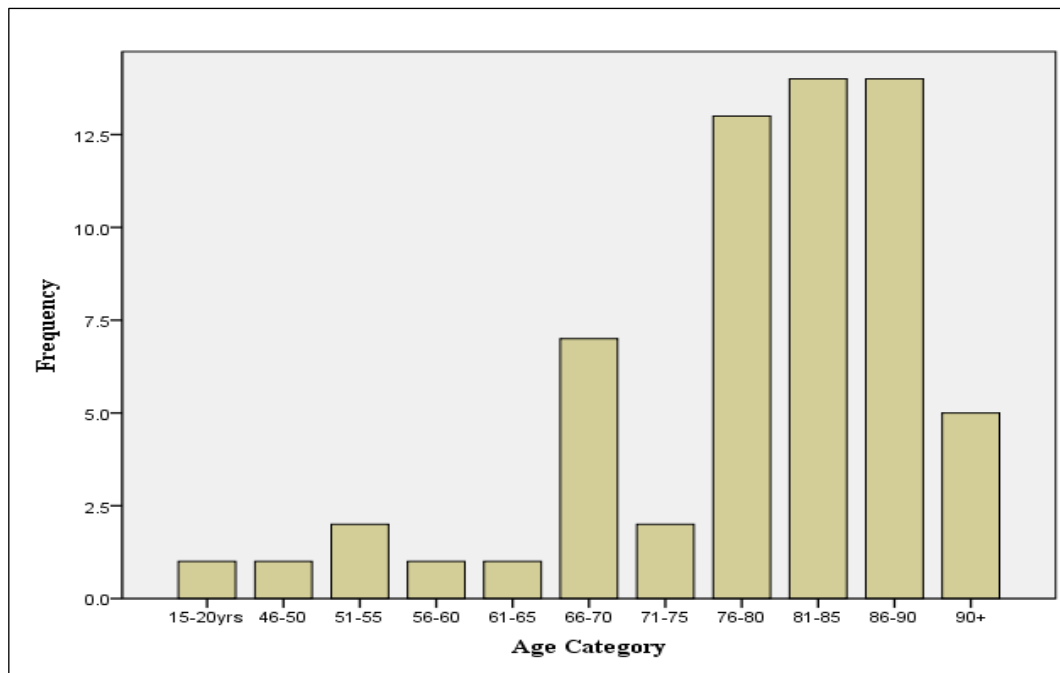


Figure 6.2 depicts patient age of those admitted during the stipulated period. The majority were older than 76 year of age. The largest group, representing 23% (n=14) were between 81 and 85 years of age whilst those patients who were between 86 and 90 years of age showed the same percentage.

The 76-80 year old group represented 21.3% (n=13) of the admissions while those who were between 66 and 70 years of age represented 11.5% (n=7). The 90 plus age group scored 8.2% (n=5) followed by 3.3% (n=2) in two age groups namely, the 51-55 and 71-75 years of age.

The smallest numbers of admissions were in the following age brackets: 15 to 20 year olds; 46 to 50 year olds, 56 to 60 year olds and 61 to 65 year olds, each scoring 1.6% (n=1) respectively.

Figure 6.3 The admission origin of fractured femur patients

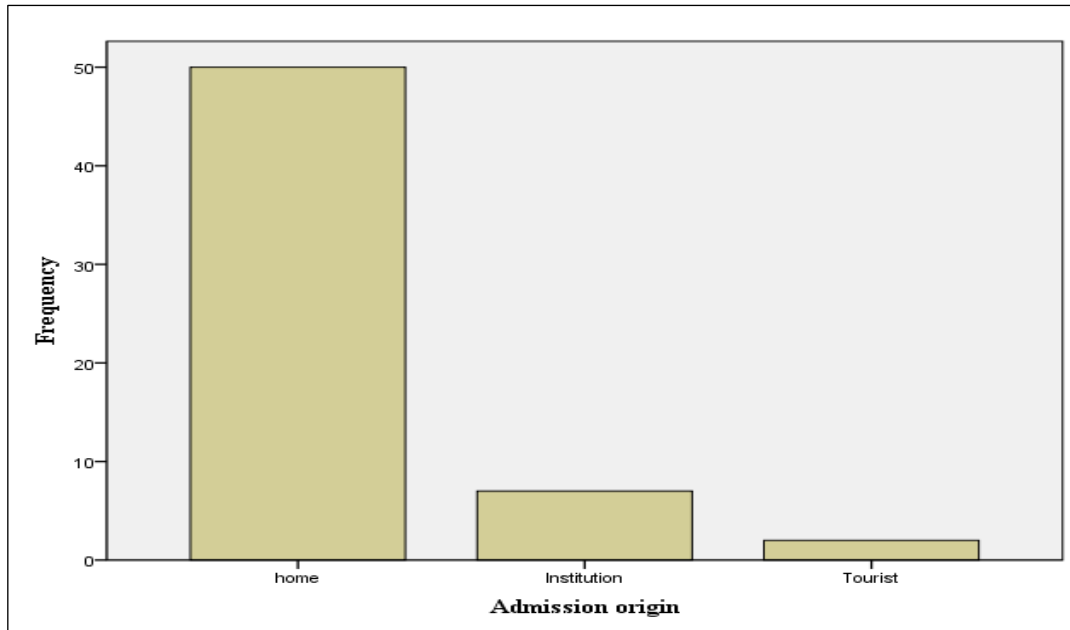


Figure 6.3 demonstrates that 82% (n=50) of the patients were admitted from their homes, whilst 11.5% (n=7) were from different institutions. Foreigners accounted for 3.3% (n=2). In the case of two admissions (n=2 or 3.3%), the admission origin had not been documented on the patients' notes.

The hospital length of stay of those patients admitted during the three-month period is presented in Figure 6.4.

Figure 6.4 Length of stay of older patients in the acute hospital

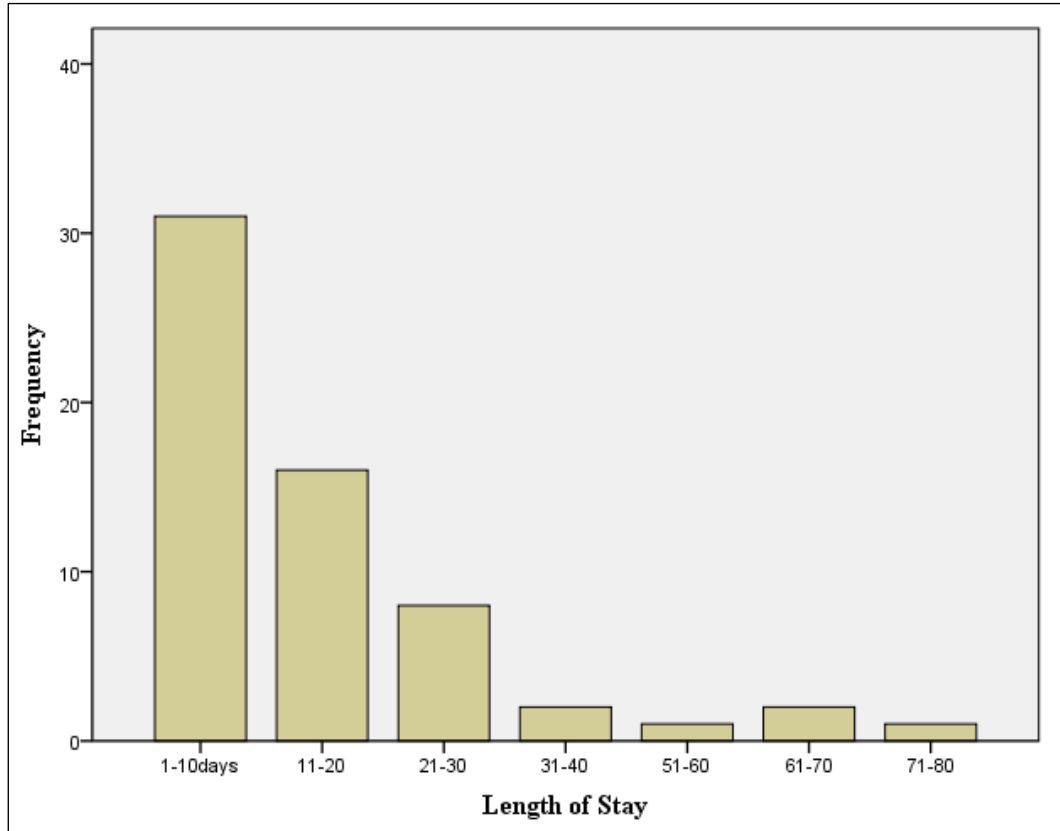


Figure 6.4 shows that half the patients (50.8% or n=31) stayed in hospital between 1 and 10 days while 26.2% (n=16) of the patients spent between 11 and 20 days, followed by 13.1% (n=8) who stayed in hospital between 21 and 30 days. Additionally, there were 3.3% (n=2) who spent between 31 and 40 days, one patient spent over 51 days, two stayed in hospital for over 61 days and another spent over 71 days.

Figure 6.5 Patient discharge destination

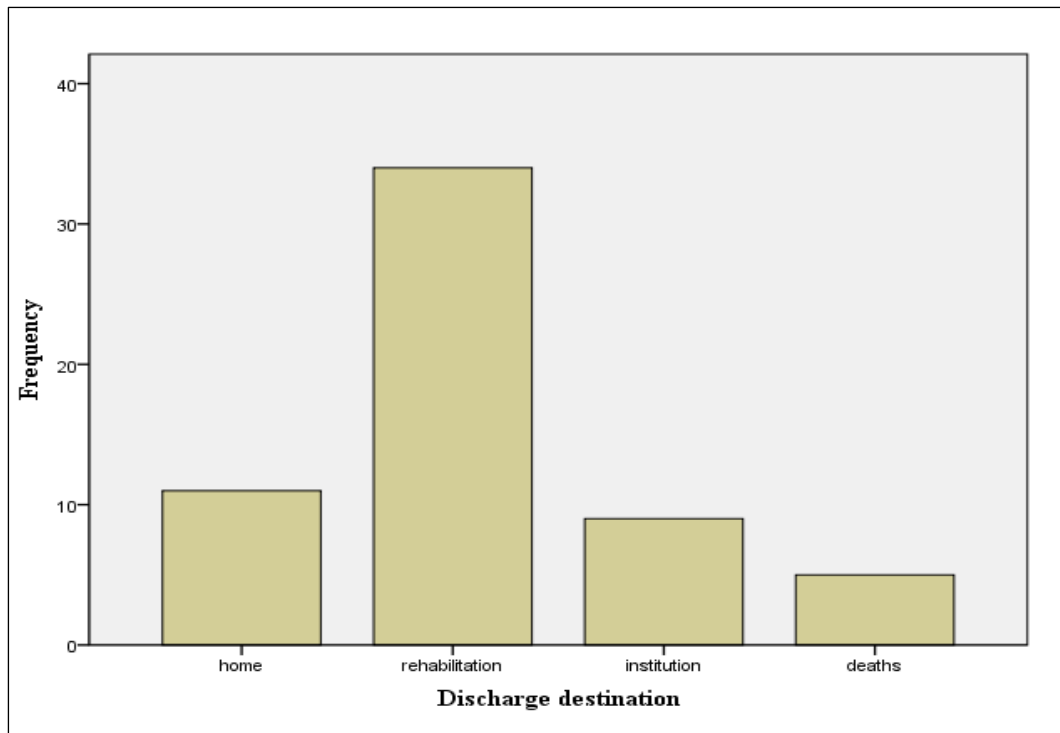


Figure 6.5 illustrates that 55.7% (n=34) were discharged to the rehabilitation hospital, only 18% (n=11) were discharged home and 14.8% (n=9) were discharged to an institution. Unfortunately 8.2% (n=5) died due to complications / comorbidities. Two patients were still in hospital at the end of the data collection period.

6.2.3 Overview

These findings presented a description on the baseline data on patients with fractured femur admitted to the acute hospital in Malta. The three-month baseline data revealed that more female patients were admitted to hospital, in the age group of 76 to 90 years old. Results showed that not all patients were admitted from home as 11.5% of older fractured femur patients were admitted from different institutions.

6.3 Phase 1: LOOK Phase – Part 2

6.3.1 Description of patients' and ICs' demographic characteristics

Interviews were conducted with patients (n=16), with their ICs (n=12) and with various HCPs (n=17). The patients were between 75 and 90 years old whilst the ICs ranged between 46 and 84 years. Those patients discharged from the acute hospital

either went home or were transferred to the rehabilitation hospital for further treatment. The interviews with older patients were conducted at the rehabilitation hospital and/or at home. Patients admitted from, or awaiting discharge to an institution were also included. A description of the patients and their ICs' demographic characteristics and relationship status is presented in Table 6.2.

Table 6.2 Demographic characteristics of patients and their ICs

Patient No.	F/M	Age	Place of interview and discharge destination	Interviews with ICs & relationship	Age	Place of interview
1.	(F)	86	Home	Husband	84	Home
2.	(F)	77	Rehab hospital (awaiting institution)	<i>No ICs</i>		
3.	(F)	81	Rehab hospital & home	Husband	82	Home
4.	(F)	78	Rehab hospital	<i>Interview discontinued</i>		
5.	(F)	80	Rehab hospital & Home	Husband & Son	54	Home
6.	(M)	81	Rehab hospital	<i>No contact with ICs</i>		
7.	(M)	87	Rehab hospital & Home	Wife	79	Home
8.	(F)	80	Home	Daughter	49	Slimming club
9.	(M)	89	Rehab hospital	<i>No contact with ICs</i>		
10.	(M)	75	Home	Daughter	46	Bakery
11.	(F)	76	Home	Husband	80	Home
12.	(M)	90	Institution	Son	54	Hospital
13.	(F)	80	Home	Sister	79	Home
14.	(F)	79		Husband	79	Home
15.	(F)	88		Sister	74	Home
16.	(F)	81		Son	51	Home

The sample of ICs (n=12) does not match that of the patients because two ICs could not be reached, another interview had to be discontinued because of pain and another older patient had no ICs. More than half of the sample of the ICs (7 out of 12) was above the age of 70. However, they were able to narrate their views about their relative's care pathway from admission until discharge into the community.

6.3.2 Results of interviews conducted with patients and their ICs

To facilitate the description of the findings and to avoid repetition, the results regarding patients and their ICs were presented together. To protect participants' identity, the patients were given a fictitious name and coded by gender. For example, Patient Female 1 (PF1, Jane) and Patient Male 1 (PM1, Peter). ICs were identified with the same number as the patient and their relationship to the patient was also given. For example, Patient Female 1's IC is described as follows - Informal Carer 1 (IC1, Husband). This continues until IC16 whilst leaving out the codes of those without an IC. Following data analysis, four common themes emerged. Each theme comprised of a number of subthemes (Table 6.3).

Table 6.3 Phase 1: Themes and subthemes (Patients and ICs)

No.	Themes	Subthemes
1.	Perceived physical health prior to the fracture.	<ol style="list-style-type: none"> 1. Daily life as experienced by patients prior to the fracture. 2. Causes of fall and immediate help. 3. Patients' and ICs' physical/psychological reactions towards fall.
2.	Patients' perceptions about the care pathway.	<ol style="list-style-type: none"> 1. Experience at the emergency department. 2. Patient perspective about the perioperative phase. 3. Perceptions on patients' stay at acute/rehabilitation hospitals. 4. Inclusiveness of care. 5. Patients' and ICs' views on pain. 6. Impact and challenges of the patient fall on the IC.
3.	Communication: Importance of information-giving.	<ol style="list-style-type: none"> 1. Overall communication with HCPs. 2. Lack of communication between hospital and community. 3. Feeling lost: Lack of information-giving on the care pathway.
4.	The importance of preparation prior to discharge.	<ol style="list-style-type: none"> 1. Perceived lack of preparation prior to discharge. 2. Support provided following discharge. 3. Perceived biopsychosocial needs following hospital discharge. 4. Patients' views on community services and intermediate care.

The various themes and subthemes will be discussed in greater detail in the following sections.

6.3.3 Theme 1: Perceived physical health prior to the fracture

This theme conveys the activities carried out by the patients prior to their fall. Whilst the majority revealed that they were independent prior to this, others required support. Participants described the cause of their fall, focusing on who had assisted them. They all mentioned that it was a shocking experience. Interestingly, some patients related this experience to their religious beliefs.

6.3.3.1 Daily life as experienced by patients prior to the fracture

Eight older adults discussed how they used to start off their day by attending church, preparing food and doing housework, whereas another two used to attend day centres twice a week. All patients explained that they were independent with their self-care activities whilst only four needed assistance with shopping, food preparation and housekeeping. This support was provided by spouse, siblings, children and family members. A male patient explained how he used to support his wife with shopping whilst another female participant depicted her caring responsibilities towards her son with special needs. Additionally, nine older adults who had experienced a fractured femur discussed that with their previous mobility they had been relatively mobile. Six patients described that they used mobility aids whilst walking and going up the stairs which offered them a sense of security. All patients stated that they were able to climb the stairs although three described that they used the stairs only if the need arose. When asked how he felt with walking, Luke answered:

Without the aid of the walking stick I used to go nowhere, and now I still use it. For me the walking stick was a sense of security, even for a few paces, I'm used to using it. I used to do everything, as long as I had the walking stick by my side (PM2, Luke).

6.3.3.2 Causes of fall and immediate help

Patients talked about their cause of fall and place where the incident occurred (Appendix 31). Interestingly, once the fall occurred, five patients mentioned that their ICs called for other family members for further support.

My son phoned his sister and she came quickly, then they phoned the health centre, the doctor came and even the ambulance came and took me to hospital (PF6, Carmen)

ICs confirmed how they called their children and another two immediately called their general practitioner. IC16 and IC8 called their siblings explaining how their parents needed help. Older ICs stated that when their own children were asked to help all had responded immediately. In fact, four ICs described how their children responded so quickly that they were at the patients' house in time to accompany their relative to hospital. The assistance provided by the children of IC14 for transferring the patient from home to hospital was timely and very much needed since there was a problem with transferring the patient from the site of injury to hospital.

I phoned my son immediately and he contacted my daughter who came at once. They (children) called the ambulance, but the paramedics could not get her out of the balcony, so first and foremost they had to lift her up and turn her otherwise the door would have closed upon her. (IC14, Husband).

6.3.3.3 Patients' and ICs' physical / psychological reactions towards fall

Various feelings were expressed by patients. Five participants explained that they felt tremendous pain and another three described the fall as a shocking experience. Feelings of loss of independence and anxiety about coping were expressed by four patients. Various patients explained that it was an unexpected experience, traumatic and sad whereas another female patient blamed herself for what had happened. However, three patients were not worried at all since it was a common fracture although surgery was required.

I can't explain how I felt, I wasn't aware whether the operation was a major one or not. I didn't think that it was a major operation. So I wasn't afraid. (PM5, Sean).

When exploring the emotional experiences of ICs upon the older patients' fall all ICs felt; worried, shocked, confused, concerned, sad, miserable and in denial. Mixed feelings of anxiety, discouragement and psychological distress were shared by most as they acknowledged that their relatives were becoming frail. In congruence with the patients' findings, ICs described how their relatives were in severe pain immediately after the accident which further increased ICs anxiety. IC12 explained how his father's fall was a traumatic experience since he had lost his mother as a result of a fractured femur. Three ICs felt responsible for their relative's health whilst others described feelings of discouragement and fear of the unknown.

I felt miserable. I woke up, and when I saw him on the floor with his head lying down my heart wanted to go out and I cried a lot. I thought that he had died. That moment he answered back I was relieved. I really felt a great shock (IC7, Wife).

Additional psychological conflicts were experienced by two ICs. IC11 explained that he felt shocked, worried and lost since he was dependent upon his wife. Besides, IC10 explained how discouraged she became upon her father's fall since as a family, they were already encountering problems with their mother's physical health.

For me it was a great shock, you have to remember that we are only two sisters and mum has already got problems. My dad is very old, I thought that if our global family situation got worse ... I saw no ray of hope. (IC10, Daughter).

IC8 exclaimed that, apart from the great shock, she was also deeply worried about her mother's coping since she was recovering from major surgery. Six patients also associated their fall with their religious beliefs. Patients expressed their trust in God and described that they prayed to God to grant them better recovery. They associated their fall to God's will on them, thus there was nothing to do about it.

My sole need was to pray and trust in God ... I leave everything in his hands. Yes, I entrusted myself in God's hands. I felt empowered a lot. God has allowed this to happen and Our Lady said "May your will be done." It is in his hands, not mine (PF6, Carmen).

6.3.4 Theme 2: Patients' perceptions about the care pathway

This theme captures patients' views of their acute hospital stay describing it as good. Conversely, some negative views by participants were revealed; postponement of surgery, noisy environment, visiting hours and others commented that the hospital transport system was awful. Patients talked about the rehabilitation hospital experience describing mixed views.

Issues with decision-making were highlighted and some participants felt that they had not been involved in their care pathway. Finally, all patients described their pain as dreadful, especially just after they fell. The impact of the patient's fall on the IC was also captured within this theme.

6.3.4.1 Experience at the emergency department

All patients, except one, utilised the ambulance services following their fall because of their inability to mobilise. Patients asserted that they were meticulously examined, however only three participants were able to recount what investigations were performed. Two patients could not recall what had happened to them at the emergency department, whilst another talked about her previous negative experience and lack of communication with HCPs.

I was taken to hospital by an ambulance, and when I arrived, they did what they had to do, took bloods and x-ray. (PM2, Luke).

Nine participants described how at the emergency department they were asked about their medical history. Only two patients talked about their waiting time for a bed at the emergency department.

6.3.4.2 Patient perspective about the perioperative phase

More than half of the patients emphasised their negative experience whilst awaiting for surgery, spending between two to four days waiting, with one patient being operated after six days. Four participants expressed the fact that the reason of spending four days was attributed to medical problems. However, there were six patients who were operated immediately following admission.

They operated upon me at once. For me personally, it's something positive that I was operated at once. (PM1, Peter).

Whilst Matthew disagreed:

I fell on Friday and I was supposed to be operated on Saturday. However, the anaesthetist did not turn up, and on Sunday morning he came. Then I was operated in the afternoon. (PM3, Matthew).

One patient expressed that, psychologically, she felt like giving up when her surgery was cancelled twice at the operating theatres but the encouragement of other patients had compensated for that incident.

I was upset, because as I said this is the third time that I am going to the theatre. You would feel like giving up, right? Facing my bed, there was one and we used to laugh ... that really helped me. (PF11, Sarah).

Patients had mixed feelings following surgery. Some felt that they were not in too much pain when compared to their pain prior to surgery, whereas others felt that they had regained their independence when they started mobilising. Conversely, two felt discouraged and thought that they were not going to recover because of wound infection. Furthermore, six patients had more than one postoperative complication including deep vein thrombosis, wound oozing and fainting.

I had really swollen legs. When I went to the clinic, I was sent straight away to the acute hospital Well, I was examined and ... the doctor told me I was suffering from thrombosis. I was very frightened. (PF9, Rebecca).

Three female patients talked that postoperatively they felt comfortable and empowered when they socialised with other patients in their room. By contrast, other patients (n=4) described that they do not want to continue with their social life because they were afraid of going out for social activities. Furthermore, when asked to compare their own health, seven patients perceived their health as at their pre-fracture level. By contrast, others (n=5) expressed that they were still not feeling well postoperatively and that they were still in pain, not as independent as before and that their physical health had diminished.

With regards to perceived spiritual needs whilst hospitalised, only seven patients talked about spirituality during their acute hospital stay, whilst none of the participants at the rehabilitation hospital referred to it. Five of these participants revealed that they were satisfied with the spiritual services given, whilst another two wanted to receive a visit from the hospital chaplain. In fact, Fiona affirmed:

Well, to tell the truth ... how I wish that some chaplain could be present so that I can confess. (PF8, Fiona).

6.3.4.3 Perceptions on patients' stay at acute / rehabilitation hospital

All patients stated that their acute hospital stay was good, most of them were satisfied with the nursing care and their daily needs were immediately attended to.

They used to take care of each and every patient. Wherever I was, they took great care of me. I have got nothing to grumble about. (PF2, Doris).

By contrast, seven patients expressed that hospitalisation in itself is an undesirable experience. Others (n=2) viewed the acute hospital experience negatively because of unnecessary preoperative starvation (due to surgery delays), two patients revealed that the acute hospital environment was noisy, whilst a participant stated that physiotherapy was better in the private rehabilitation centre.

I didn't used to sleep much near the other patients but here (rehabilitation hospital) the place is much quieter. Over here it is better because of the quiet (PF4, Mariah).

Moreover, five patients utilised hospital transport and described it as an awful experience because of long waiting time and the transportation process. Patients felt miserably in pain since it was not a smooth trip and it was even described as an unpleasant experience by the ICs who accompanied their relatives.

Well, we decided to take the hospital transport ... If I had known what a bad time we would have, I wouldn't have selected it (IC1, Husband).

Other negative concerns were discussed by three patients about being cared for by the opposite gender, since it was an uncomfortable experience. Sarah commented:

The only time I was shocked was when I asked for a bed pan and I saw a young man coming with it. Well, you feel embarrassed. (PF11, Sarah).

Furthermore, perceived perceptions on the acute hospital disclosed mixed feelings by ICs with five of them viewing their relative acute hospital stay as very good. However, two ICs talked about how the visiting hours had kept them away from their relatives when they were needed most. Other perceived negative issues by ICs were the short stay at the acute hospital, lack of psychological support, postponement of surgery and lack of information. IC14 conveyed feelings of disappointment, anxiety

and anger because he was left waiting for his wife without being given any information of what had happened to her in the operating theatre, apart from experiencing a change in ward.

Giving the right information at the right time was perceived as crucial by IC11 who recalled how shocking it was when the ward nurse phoned him when his wife was in surgery. Although it was simply an information-giving exercise because his wife was being transferred to an orthopaedic ward postoperatively, he thought that something awful had happened to her. This demonstrates problems with communication that exist between the HCPs and the service users. IC16 confirmed how his mother had an unpleasant experience when she was transferred twice to theatre and surgery was rescheduled in view of further investigations.

Three ICs disliked the rehabilitation hospital environment and the process took too long and for this reason, they selected private services. IC8 selected a private rehabilitation hospital, whilst IC7 provided her relative with rehabilitation services at home. IC12 perceived his father's rehabilitation programme as very positive whilst he was disappointed with the carers' approach. Similarly, IC3 described similar experiences whereby he explained how his wife was not allowed enough time to stay on the armchair following lunch. This could mean that the hospital systems function on routine practices, rather than on the patients' needs.

... there were some who really did their job well, but there were others who really annoyed me. Sometimes after getting her out of bed to eat, they wouldn't give her enough time and get her to bed straight away. (IC3, Husband).

Similar to the acute hospital, six patients out of seven felt very respected and satisfied with the care given at the rehabilitation hospital. However, two patients compared the rehabilitation hospital environment with that of the acute hospital explaining that the acute hospital is better since it is newly built. However, they discussed that it was busier than the rehabilitation hospital.

Well, I am settled here and sometimes I think that it's better here. Over there it's more hectic. It's a totally different environment here. (PM1, Peter).

With reference to the rehabilitation hospital, patients perceived the rehabilitation hospital as a place for therapy (n=3) and as a form of continuity of care (n=2). By contrast, Sarah refused to go to the rehabilitation hospital since she did not want to go from one hospital to another, whilst Matthew looked at it and disliked it as he felt it was like an institution. Some patients expressed dissatisfaction with the physiotherapy assistance since one spent a lot of time before becoming mobilised, whilst another confirmed that his private physiotherapist encouraged him more. Finally two patients, together with their ICs, illustrated the support they were given during their transfer home when a team assisted Rebecca home, whilst Therese was given a home visit.

6.3.4.4 Inclusiveness of care

Patients (n=10) expressed that they were not included in decision-making, especially in anything concerning their care, mobility and discharge or transfer.

I don't think that they asked me or approached me to ask me whether I wanted to be discharged. No, I never remembered that they included me in the decisions taken. (PM1, Peter).

Alternatively, three patients explained that they were happy to leave decisions up to the doctors, together with their ICs. Only, two patients expressed that their consultants involved them in decision-making about their own care, whilst another patient explained how he decided together with the physiotherapist about the best mobility aids. Nicole stated:

I told them that I would leave it up to them; it's their decision and not mine. (PF5, Nicole).

Half of the ICs in the sample expressed that they were not included in decision-making, for either the care pathway or the discharge process. Moreover, IC14 explained that decisions about surgery and rehabilitation had already been taken by

the team without involving him or his children. IC1 revealed that although he was not included in his wife's care pathway, he agreed with all the decisions that had been taken on their behalf. IC15 claimed that the team spoke to her often and that she had to decide on behalf of her sister (the patient) who would become confused.

They primarily used to tell me what was going to take place, and I used to bring anything my sister needed. I think it was I who signed for her operation (IC15, Sister).

Only two ICs expressed that they were involved in decision-making. IC8 was very pleased that the surgeon had decided for her mother to proceed with surgery, since surgery was questionable and necessitated a medical decision. Two ICs talked about how their parents had trusted them to make decisions on their behalf. IC12 explained that he was continuously involved in decision-making and since he was a nurse, he used to decide with the medical team and then inform his father. He explained how his father disagreed with him about the rehabilitation but since his father trusted him, he collaborated. This sheds light on the paternalistic attitude that relatives sometimes adopt, so that decisions are taken for the benefit of the patient.

By contrast, other ICs (n=4) discussed that their relatives also need to do their part and involve themselves. IC12 explained that his siblings were unwilling to participate in their father's care pathway. Interestingly, five ICs viewed involvement in the patient journey by supporting them emotionally, by being near and providing them with personal belongings and with all their needs. IC10 believed that participation could enhance patient care and be advantageous to the nurses, since relatives can lend a helping hand. Others felt that their presence would empower the patient, enhance the rehabilitation process and prevent loneliness. IC11 explained:

I was involved due to the fact that I was always there to support her and that if she needed a shoulder to lean on ... I think that the relatives have an important role because it is impossible to cater for all the patients. (IC11, Husband).

6.3.4.5 Patients' and ICs' views on pain

All patients talked in great depth about their pain and although they were given pain relief on admission, they described it as shocking and severe in intensity. Some cried and screamed in pain whilst another patient fainted.

I started screaming with pain... the pain was so severe that not even during labour, did I feel such great pain. (PF5, Nicole)

Other pain experiences disclosed by patients and related to the fracture included pain due to a sacral sore, calf pain and shoulder pain. Furthermore, participants discussed their pain management and the majority (n=14) were satisfied with pain relief. Only two males disclosed that they needed more analgesia and Peter exclaimed that if he had been given adequate pain relief he would have mobilised better. Three participants explained how their pain was completely relieved, postoperatively.

Although the majority were satisfied with pain relief management, findings reported that nine patients were still taking pain relief medications after discharge, even though they were experiencing minimal pain due to the medications prescribed by their doctors. Two explained that they were trying to decrease their pain medication since they were not in too much pain. Two patients explained that there was no need for any other therapy since the analgesia they were given was enough. However, another explained that if he was offered an alternative therapy for pain relief, it would have helped him and he would have been happy to consider it.

With regards to ICs, three sadly described how their relatives were in severe pain especially during transfer to hospital. IC15 described the experience as very stressful and agonising seeing her sister in severe pain. IC3 added how his wife's pain was not well managed and her chronic osteoarthritic pain had caused his wife to become housebound. ICs findings seem congruent with those of the patients whereby four ICs revealed that they were not given any information on how to help their relatives manage their pain. Only IC12, who is a nurse, added that he was given information on pain management upon asking his father's medical team.

6.3.4.6 Impact and challenges of the patient fall on the IC

With regards to the impact of the patient fall on the ICs health, three elderly ICs discussed that they were not physically healthy and were encountering physical problems, such as back pain. Some other ICs felt emotionally and physically exhausted with the new responsibilities of taking care of another older adult. What is distressing is that ICs felt that their health was deteriorating and that they couldn't cope with the caring demands. By contrast, two elderly ICs expressed that they felt healthy and were able to look after their injured relatives. IC 15 explained:

I had a replacement here, a hip and knee. This one is hurting again, because it's been 40 years since I was operated and I'm limping again. Well, sometimes I am getting tired and my back hurts, even washing the plates, because sometimes I can't bend as much as I want, especially when it comes to washing her legs. This makes me suffer a lot (IC15, Sister).

ICs also described the impact of the patient fall on the whole family and not just on an individual member. Four ICs talked about how their lives were socially changed and their families were abandoned as a result of dedicating more time towards their parents. This was illustrated by a son who described that his father had to limit his activities following his mother's fall, his sister had to come and help his mother early in the morning prior to going to work and that his wife had to prepare the food.

The impact is really strong, a lot. Really gets a strong hold of you, the whole family. It affects the whole family not an individual. (IC5, Son).

Other ICs revealed that it had not affected them since they are pensioners. Some ICs expressed that their jobs were affected and it was revealed by IC10 that she had to decrease her working hours, whereas IC5 explained that to keep his job he had to visit his mother early in the morning.

Well, my job yes, because not to affect it, I have to come here at 4am like my sister does. (IC5, Son).

All ICs described the financial aspects and they commented on the expenses they were incurring. Four ICs added that they had to purchase expensive anti-thrombolytic tablets, osteoporosis treatment, physiotherapy sessions and private

carers. Other expenses mentioned by two ICs were that they had to pay for domestic cleaning, whilst IC7 mentioned paying a private carer to help her with the care of her husband following immediate discharge. Conversely, IC8, who is self-employed, did not remark on the financial impact as a result of her mother's fall but said that she was willing to pay for her mother's care.

She stayed at a private rehabilitation hospital for ten days. It cost me two thousand euro. In our case, we had to bring a carer; it cost us a thousand euros a month. There is another person who cooks for her against payment. I used the services of a physiotherapist too. (IC8, Daughter).

The ICs talked about the time dedicated to the care of their relatives with six of them mentioning that since they live together being either a spouse or a sibling, all their day is dedicated to their care. Three ICs try to find a balance between work, family and the older parent.

6.3.5 Theme 3: Communication - Importance of information-giving

In this theme, participants acknowledged various factors hindering the overall communication. Their level of satisfaction with communication was viewed as satisfactory by most of the patients. Conversely, participants discussed HCP's informal communication in front of the patient as unacceptable. Most patients described that they needed more information on their care pathway in relation to their operation, rehabilitation and discharge.

6.3.5.1 Overall communication with HCPs

When asked to rate their communication with HCPs using a Likert scale, patients revealed an overall satisfaction. Eleven patients rated between eight and seven, meaning that they were very satisfied with communication, whereas four patients rated dissatisfaction with communication and another patient did not comment.

They were very reasonable, communicative and their relationship was very good. They were so sweet and they really had a caring attitude, that you feel that they go out of their way to help you. So you feel happy. (PF6, Carmen).

Although most of the participants were satisfied with the communication, some talked about the need to address the patient directly rather than HCPs talking amongst themselves without giving any feedback. Participants' (n=5) problems with communication with HCPs were the following: communication amongst HCPs without addressing the patient; use of other language; unidentified HCPs to the patient; HCPs talking about personal issues in front of the patient and discussions with students about the patient without asking permission or addressing the patient.

When the professor came to do the ward round, he would be accompanied by his team and you wouldn't be sure if you had enough time to speak to them. Sometimes they used to start to speak between themselves and I couldn't understand anything. When they used to speak in English I literally couldn't understand anything. (PF3, Angele).

It was further noted that due to lack of communication, three participants were unaware of who was their caring consultant. Yet another patient discussed that she used to listen but she did not receive any feedback whatsoever, whilst three participants added that they were not given enough time to communicate with their consultant. Four participants described how they used to understand the discussion, whilst two of them pointed out how the geriatricians used to communicate better with older patients without using any jargon. Patients identified factors enhancing their communication with HCPs including: ample time; good communication skills; nonverbal cues and frequent visits. The factors hindering communication were: lack of time and workload; hectic ward; shortage of staff; no explanation or unknown HCPs and not wanting to bother HCPs.

Sometimes it's true I had to wait because they are short of staff. I think it's the workload that hinders their communication and presence with us. (PF16, Sarah).

The significance of the relationship between HCPs and patients was stressed by two ICs. IC8 explained that patients should not only be given the opportunity to discuss medical issues but a holistic approach should be adopted. IC12 revealed that the relationship built between his father and the geriatrician had empowered his father.

6.3.5.2 Lack of communication between hospital and community

An issue with the lack of communication between the discharging hospital and the community doctor was deemed to be important by the participants. In fact, the participants (n=10) themselves informed their general practitioner about their hospitalisation, whilst another four did not inform their doctor at all. Most of the patients mentioned that their general practitioner had been informed after the fall or following discharge.

Even when I had my leg swollen, I got her too. As soon as I was discharged from hospital, I called her straight away and she gave me the iron tablets. (PF8, Fiona)

Two patients expressed that they were asked by the hospital doctors to contact their own doctor and the dentist. Angele talked how she became confused due to disagreement on treatment between the rehabilitation doctor and her family doctor.

6.3.5.3 Feeling lost: Lack of information-giving on the care pathway

The lack of information-giving was discussed by twelve patients describing that they had felt at a loss and confused following discharge. All participants explained that they were informed about the need for an operation because of the fracture. However, patients expressed that no one had explained what type of fracture they had and the type of operation they required (n=8), what anaesthesia they would be administered (n=5), type of sutures (n=3), advantages and risks of surgery (n=1).

... they told me that I needed the operation, but then ... nothing. I was lost ... all he told me was that I had a fracture and I needed the operation. They didn't tell me anything about anaesthesia because I had undergone other operations before. (PF7, Charlene).

Half of the patients added that they needed information on recognising wound infection, results of blood-letting and information on their hospital length of stay. Four participants stated that they required information regarding their prognosis, rehabilitation process and coping strategies. Patients who talked about the impact of lack of information also described continuous feelings of uncertainty about their walking abilities. Patients revealed that they would have felt more empowered if

they had been given more information. Participants emphasised that not knowing what to expect was stressful and confusing. Jane recounts how she obtained information not from HCPs but from an outside source. Fiona commented:

It's really a mystery that I cannot understand. Nobody told me anything. So many of them came, either to take some blood or for any other reason that I expected that they would tell me something about what they were doing but they just drew some blood and that's that. (PF8, Fiona).

Three patients were satisfied with the information given to them and they were aware of the medicines they were taking. Three patients requested more information about pain management. Interestingly, one participant acknowledged that she always took the treatment without feeling the need to ask.

I take every kind of pill they give me. I take analgesics, I can't remember their names. (F2, Doris)

The informational needs on pain management were mentioned by seven ICs. Three were concerned about their inability to help their relatives due to lack of information. IC1 expressed how worried and uninformed he was when, due to pain, his wife was unable to walk. IC11 shared feelings of frustration, however, he managed to cope by documenting the time of treatment and by reminding his wife of the due time for pain relief. IC5 seemed unsure about what pain relief his mother was taking.

Two ICs talked about how they questioned their relatives about the medications they were administered and patients seemed unaware about the treatment they were taking. IC10 discussed that her father was reluctant to ask. She mentioned that nurses used to explain that he was given a pain medication but he remained unclear about it. It seems that although a gap on lack of information exists, the issue is the absence of obtaining feedback on the patients' understanding.

He used to tell me, "Mary, they gave me a pill but I don't know what it is." I used to tell him to ask but he is so shy and reserved that he wouldn't do so. (IC10, Daughter).

All participants questioned why they had not been informed earlier about their transfer to the rehabilitation hospital. Patients asserted that they wanted to be informed in advance because they required time to decide (n=2), needed time to inform their relatives (n=2) and for all participants, the transfer took place haphazardly and without warning. Three patients felt the transfer process was unfair, especially the way they had been informed just before the transfer.

I wasn't so pleased about the transfer. In fact, once there were the doctors (geriatricians), they used to come and see me every day during the ward round; one mentioned the word K... and I told them it is too early for me to go there ... he told me "Now it's too late" ... and I should have gone there before. ... It would have been much better; if they would have told me "Next Monday we will transfer you to the rehabilitation hospital" (PM3, Matthew).

With regards to follow-up appointments, only five patients were informed about their appointments. The remaining participants were concerned about their follow-up visit. However, some consultants do not request further follow-ups and because patients were not informed about this practice this caused unnecessary anxiety. Four patients felt satisfied with the information they were given by HCPs about their care. One explained that she was well informed and encouraged with the information given by her consultant. Two patients were continuously supported by their IC; one participant was supported by her daughter who used to constantly communicate with the HCPs about her mother's progress and the other by his son who is a nurse.

Whilst acknowledging lack of information-giving, half the participants stated that they were given information by physiotherapists, mostly on the use of walking aids. Some recalled that they received training sessions by Occupational Therapists (OTs).

I was visited by two girls, I think they were therapists. They gave me a paper to fill and we bought a seat. They were a great help as they showed me how to wash and gave me many good tips. (PF1, Jane)

Likewise, the same views were shared by ICs about the need for more information. Eight ICs revealed that they were told immediately about the diagnosis, their

relatives' extent of injuries and that surgery was required. IC8 also acknowledged how encouraging it was when her consultant explained that it was likely that her mother would walk again. IC14 described that he was given continuous information by his wife, since she used to inform the family in detail about her care pathway. This was further supported by IC3 in that he was summoned by the geriatrician to speak about his wife's condition.

Conversely, ICs' informational needs were mainly on the patient hospital stay, pain management, discharge and follow-up care. Four ICs conveyed that the information they were given was focused on surgery and not on their relative's care pathway, whilst they stressed that they would have been more prepared for their relative's discharge if they had been better informed. Three ICs found their own method on how to obtain factual information which was through their own daily observation. IC10 obtained continuous information through telephone calls with her father. Observing his wife's progress was the main source of information for IC11.

I was aware of what was taking place, because I was with her all the time. But they give you no information at all. Otherwise, I would have been prepared better to take on this role (IC11, Husband).

Four ICs shared the trusting relationship with their children, whereby they explained that their informational needs were met by their children and was perceived as very reassuring. Two ICs stated that their children were more knowledgeable and hence they used to continuously inform them about their parents' progress.

I was not given much information. Jane used to lead us. Well, it was Jane who usually took care of everything. They never told me anything. They know better than we do. It was always our children who paved the way. (IC7, Wife).

Three male ICs were annoyed with the lack of information-giving and when some information was given, it was very superficial. IC3 requested detailed information about his wife's operation, whilst IC14 explained how he waited anxiously for his wife to return from surgery for a long time and without receiving any news. He felt that he should have received more information during the perioperative phase.

The quality of information was also discussed by three ICs who expressed their concerns about lack of information about the patient's pathway, especially on mobility. Besides, ICs claimed that when they were informed, the information given was incomplete which caused them frustration and decreased their trust in the healthcare system. Two ICs explained how they were asked to complete a measurement sheet but one was never collected, whilst the other IC stated that she never received any feedback. The ICs emphasised the responsibility they felt towards their parents and siblings, since they were worried about taking the wrong decisions which might have worsened their relative's condition. IC10 expressed how ridiculous she felt when her sister enquired about her father's surgical site infection and her feedback always was that he was being given the necessary treatment.

Five ICs talked about the difficulties encountered with the follow-up appointment of their relatives. Two were unsure about the date and time; another had not received the appointment at the time of the interview; whilst another two were given the appointment upon discharge without a time. IC10 revealed that following discharge, she was not informed about further investigations and follow-up care at the acute hospital. However, IC15 emphasized:

I was not given any information about any outpatient appointment but there were nurses who worked in the community and one of them used to come here (home). She told me to call them whenever we needed them so I will ask her. (IC15, Sister).

Although not all ICs were satisfied with the information given about the patient care pathway, IC12 and IC8 felt that they had to ask for information themselves. Interestingly, these two ICs seemed to justify that the lack of information given to patients and their families was due to the HCPs' workload on the wards.

I'm not the type of person who waits for information to be given to me, but I ask for information straight away. I used to come and wait for the consultant at 7am daily (IC8, Daughter).

Patients suggested that HCPs should spend time with patients informing them about what is expected during their hospital stay. IC10 added that it made more sense for information to be given during visiting hours.

Another four patients explained that they might have been given information but they may have forgotten it. Some requested that upon discharge, they should be given more written information.

It would have been much better if I had more information, especially something written because I have children, I even have children abroad and they would need to make the necessary arrangements, you know (PMI, Peter).

6.3.6 Theme 4: Importance of preparation prior to discharge

Factors influencing the discharge process were considered whilst participants' needs upon discharge were emphasised. Participants' awareness about the available community services and intermediate care in Malta were other issues discussed.

6.3.6.1 Perceived lack of preparation prior to discharge

All patients discussed the factors that had influenced their discharge process (Appendix 32). A participant narrated how the change in discharge destination had confused him since he had expected a period of rehabilitation and instead he was sent home. IC11 conveyed his frustration about the inconsistencies in the discharge process which caused him a long period of waiting time, together with an unexpected change in the discharge date. Three ICs commented that it took hours for their relatives to be released, since they had been waiting for the discharge summary which caused unnecessary stress to the patients.

I think the discharge planning was a bit far-fetched. She was not going to be discharged because the person who was going to discharge her did not turn up (medical consultant). This was also a bit unfair. I wasted 5 hours waiting around ... and I had already taken two big bags to the car and I had to bring everything back. (IC11, Husband).

Discussing their discharge planning process, five patients added that they were only involved in their discharge on the day when their consultant discharged them and they were able to go home. Since they had not been informed in advance, they were not offered other options and neither were they given time to think and prepare for

their discharge. A patient described that she had signed a refusal form since she was not given any choice on her discharge destination.

Patients felt that they were unprepared for discharge and the sudden transition had caused them stress, apprehension and panic for their ICs. Some expressed that since they had not been informed in advance, their home environment was not completely prepared for their needs. Other patients also added that they were not well prepared physically and psychologically. Doris stated:

... she told me that same day that I was going to be transferred here (rehabilitation hospital). I was amazed and asked them why this was taking place all of a sudden. (F2, Doris).

Only three patients and their ICs discussed that they had an expected discharge date, of which in the case of two, it was not even abided by. Patients explained that although nursing staff hinted to patients about their discharge, they were told that the decision had to be taken by their consultant. This highlights the dominance of the medical model within the hospital system.

I always used to ask them how long I would stay in hospital, and they used to answer that it was up to the professor. (PM4, John).

Conversely, four patients commented that their ICs were involved in the discharge planning process together with the HCPs. Patients explained that their relatives had planned all their discharge needs including: booking a private home for respite; a private rehabilitation hospital; physiotherapy at home and carer assistance. These services were offered against payment and were chosen by the patient or their ICs.

Yes, I got one privately and I used to pay him. I used to pay him twenty euro. He could come as much as he wanted, but he was very prudent. (PM5, Sean).

Participants expressed their views about the HCP's role in discharge planning. Two ICs stated that information-giving would help the patient to adjust and make the home environment more comfortable.

Well, my children had already planned everything. We knew where we would go after being discharged and how they would help me. They prepared everything before she was discharged; they even brought a bed to my house. (IC1 Husband).

ICs (n=4) revealed that they were informed about their relatives' plan for the rehabilitation hospital. However, four ICs showed their dissatisfaction about the fact that they were not informed when the transfer was to happen. IC3 talked about his frustration on this issue, explaining how he had just arrived home after visiting his wife, when he received a call informing him about his wife's transfer and he had to go back to accompany her. IC15 however, stressed that at the rehabilitation hospital she had been informed three days in advance about her sister's discharge.

ICs reflected the perceived inadequate preparation for discharge planning including: unexpected discharge; changes in date and destination and prolonged waiting time for discharge letter. Additionally, ICs claimed that they were misguided and lacked information on pain management, coping strategies and mobility.

In hospital nobody told me anything ... so we tried to do our best. I think they have to tell us something about what's going to take place, how to cope with the patient ... and how to help her. (IC13, Sister).

Conversely, IC14 suggested that knowing about discharge is beyond his role and thus, he never asked about his wife's expected discharge.

I never ask them whether she would be discharged or not, that's their business. (IC14, Husband).

IC1 revealed how satisfied he was with the information given on home adaptations by the OT. Whilst preparing for his wife's discharge, he was going to change the bathroom but with the OT's advice, the problem was resolved by buying a bath seat.

6.3.6.2 Support provided following discharge

All patients felt that they were supported by their ICs whether they were siblings, children and spouse. Participants described how their children made adaptations in their own homes to keep their parents for respite, prior to going back to their home.

Interestingly, patients expressed that their children, together with their family, share their responsibilities and supported their parents even though they have work and family commitments. Patients felt respected by their ICs and expressed their gratitude towards them.

My children support me and even this daughter that I am staying with. I feel like I am staying in a five star hotel. Everybody lends a hand, even my granddaughter and my husband. They share responsibility. (PF1, Jane).

The patients felt that the support that they were provided with had encouraged them and they expressed gratitude that they had frequent visits from extended family members, parish priests and friends. Five participants appreciated the support received from religious communities. Therese explained:

At the end of the month, the parish priest comes to give Holy Communion and even the vice-parish priest. Even the members of Legion of Mary come to visit. (PF10, Theresa).

All ICs explained how they supported their relatives with self-care needs, mobility, helping parents with house chores and shopping and assisting them with follow-up appointments. Additionally, ICs described the support they received from other family members, since most of them (n=8) are quite elderly. IC10 talked about shared responsibilities between the siblings, whereby one takes care of their parents' daily physical needs whilst the other assists with hospital visits.

This week we went to the dentist and my son drove us there. He also wanted to pick us up afterwards. We told him we could use the public transport, but he insisted ... Yesterday, my daughter was here because my wife cannot clean the house. (IC1, Husband).

Three ICs talked about family closeness by explaining that all members do their utmost to help. IC7 stressed that even their grandchildren contributed, by assisting their grandfather with self-care needs which was very encouraging for the patient. However, IC12 expressed feelings of loneliness and responsibility when caring for his father and he wished that he could have had someone to share his feelings with.

They left everything in my hands but I really needed to speak out my emotions, because to tell you the truth, certain emotions were very preoccupying for me and I really wanted to share my feelings with someone, but unfortunately no one was there for me. They weren't aware of how I was feeling; how I was managing to go to work and take him to his hospital appointments. (IC12, Son).

6.3.6.3 Perceived biopsychosocial needs following hospital discharge

All participants claimed that they had to make adjustments in their own homes, since they were not suitable to accommodate their contemporary needs (Appendix 33). All patients identified some physical needs following discharge. Those discharged from the acute hospital described their recovery period as being characterised by difficulties in meeting their physical needs. They explained that with mobility aids they were managing to mobilise, whilst four were still unable to climb stairs.

ICs discussed the patients' progress following discharge and most of them (n=7) expressed satisfaction with their recovery. IC11 said that his wife was improving satisfactorily, whilst IC12 insisted that he had never expected such improvement, considering his father was ninety years old. Conversely, some ICs explained that although patients were progressing, the recovery process was taking time and their relative still required assistance in self-care needs and help with mobility.

IC7 described that at the rehabilitation hospital, her husband had been progressing very slowly but when he signed responsibility for his discharge, his health improved. This possibly reveals that successful recovery may, in some cases, be dependent upon the patient's own self-goals.

... she told him that she would take him home and bring him private care. Over here it's much, much better. The day after he was discharged, he removed his nappy and he even shaved. Now, he's practically doing everything on his own. (IC7, Wife).

With regards to physical needs, some ICs explained that their relatives required some assistance with the ADLs (Appendix 33). IC16 added that his mother did require assistance as she is the main carer of his brother with special needs. IC5 recommends:

I thought deeply about it, I thought about it all from the fall until rehabilitation. You can't leave her on her own. She needed help in everything. One suggestion I would make to the authorities is that people in their eighties, if the state does not want them in hospitals, they should be provided [them] with a carer at home ... (IC5, Son).

Findings in this study imply that patients throughout their journey went through a period of psychological distress, such as: denial; uncertainty; boredom; apprehension; discouragement; guilty feelings towards their family members; helplessness and feelings of dependency on others. A patient explained how it took her quite a long time to come to terms with the incident and she attributed her success to her family support. Alternatively, two patients expressed positive feelings towards self and they felt satisfied and happy with their lives.

Patients also expressed that since they were limited with their mobility, their social life had been affected. Male participants expressed that, in the future, they expected to continue with their usual social activities. Other patients expressed the need to empower themselves because they were recovering quite well. Some female participants explained that they had given up their social activities after their fall.

I have been going nowhere since I fell. Before I used to go to church because it is nearby, but these days I'm shy to go to church using these two sticks. No, I don't want to go. (PF5, Nicole).

All participants were Roman Catholic and three participants referred to their spiritual needs and that they planned to resume their previous activities when they became more independent. Some participants revealed that holding with religious practices, such as putting their trust in God or considering the incident as God's will, helped them cope. Three participants appreciated being offered Holy Communion at home. ICs talked about their spiritual needs and stressed that they adjusted according to the situation. Two ICs discussed how they attend religious activities together with the patient, whilst IC12 explained that when his father is at home, they pray together. Some ICs explained that they met their spiritual needs if family members were able to substitute them in their caring duties, so that they could go to church. This

suggests that older patients are not left alone, especially following discharge. Also, IC15 explained how she meets her sister's spiritual needs.

... up till now I am still going to church and my brother comes to replace me. Even when I used to go to the prayer group twice a week my brother used to come ... Even she tells me to go. I give her Holy Communion every day. The Parish Priest gave me permission. (IC15, Sister).

With regard to ICs, perceived psychological needs were continuously supported by being near their relatives and receiving constant encouragement and reassurance. Furthermore, ICs discussed their fears, uncertainty and panic which were common factors in the post discharge period. This was illustrated by IC12 who explained that he ensured that his father recovered well, whilst helping him build his self-confidence. IC12 continued how his fear was transmitted upon his father and had discouraged him enormously.

I might have added more to this lack of self-confidence because I keep on telling him to pay attention to how he walks, because I was afraid that he might fall again. (IC12, Son).

Three ICs also commented that they continuously advised their spouse to be careful whilst walking. The ICs talked about the psychological support their relatives needed immediately after discharge and until they adjusted to daily life, such as being afraid to walk unsupported and because of the pain. The ICs expressed that the fear of falling again caused patients unnecessary anxiety, as well as functional decline. This was illustrated by IC14 who explained how his wife did not want to stay alone at home because of her fear of falling. This was making him stay at home with her.

The ICs revealed that they felt lonely, emotionally tired with the overwhelming new responsibilities and anxious about coping in the future. Guilty feelings and fear of the unknown were expressed by IC12 stating that the fact that he had to send his father to an institution and the fear of his father becoming bed-bound were terrifying.

I felt great responsibility and I felt certain deep emotions but I could not speak ... to anyone. My dad and I are like a family because we live together. It doesn't make a difference to my siblings if my dad is in a home

or not because they're not going to miss anything. But I was careless because I left him alone. But I couldn't leave work. (IC12, Son).

IC10 explained feelings of loneliness because both parents were dependent and felt the responsibility of decision-making. She was also concerned about her parents' future. Two other ICs recommended psychological support in order to prepare relatives with coping strategies following discharge.

Only one IC felt that he was coping with his wife's needs post discharge whilst acknowledging his children's valuable support. IC13 disclosed that although she was coping, she needed reassurance because of over-reliance and the demanding attitude of her sister. IC13 explained how reassured she felt after she had discussed her worries with her general practitioner.

I think someone offering reassurance can help a lot. Even someone offering advice. I remember even when I went to Dr ____ and she asked me why I looked so worried. I told her what was troubling me. She also told me to go to see her whenever I am worried, and that is a great relief. (IC13, Sister).

Some female ICs felt sad because they were missing their social activities. Some ICs expressed that they could not continue with their hobbies and social life and they mentioned not going for a walk, not gardening, not attending church, nor going to the day centre because their relatives needed their assistance.

6.3.6.4 Patients' views on community services and intermediate care

Half the patients were not aware of the available community services, whilst another four participants revealed that they do not need any community support (Appendix 34). When community services were mentioned to participants, some did not even know about them, let alone know how to ask for them and what the costs were.

... I'm not sure of such services. All I know is that they can help you. However, once we are living with my daughter, I don't need anything. (PM4, John).

Some ICs (n=5) perceived the important role HCPs have to inform patients about community services when discharging a patient. They mentioned that the general public should be informed about all the available resources. IC7 stated that this lack of knowledge was due to the fact that her husband might have forgotten the information given. IC8 suggested that to prevent institutionalisation, there is a need for promotion of community services.

Relatives should be given information of how to use the services of occupational therapists and physiotherapists too. Well, I had to make use of the private service of the physiotherapist, but if there were some in the community ... this would have been a great help too. (IC8, Daughter).

When discussing their views on community support, three ICs conveyed that there was no need for further community services, unless these are provided consistently. However, half of the ICs stressed the need for improvement and suggested additional community resources. Suggestions for improvement were an increase in home help, availability of community physiotherapy and the need of a social worker. Two ICs continued that although social workers can reassure the ICs, they can also provide guidance about the existing community services.

It would help her a lot if the physiotherapist himself had to do a home visit. The thing that I would really like is that they would come to the patient's home. (IC11, Husband).

Positive views were highlighted by four ICs about community nurses and they explained how encouraging and beneficial their services were to their relatives. IC7 emphasised how committed the community carer was with her husband.

Like the one who came today, she is really good and I really was pleased with her. She helped him with taking a bath, changed his clothes, washed the bathroom and cleaned up some water that was on the floor ... She took him by the hand and helped him to walk a bit. (IC7, Wife).

Conversely, three ICs remarked that the community nurses' visiting time had restricted them with their activities, since visits were unscheduled.

What sometimes might sound like a burden is the fact that either you have to wait for the nurse or the telephone to ring. I can't even go in the yard because I am afraid that I might not hear her. (IC13, Sister).

Very few participants (n=4) understood what is meant by intermediate care and following an explanation, most of the patients and all ICs perceived it as very advantageous. They preferred it for the following reasons; enhances communication with HCPs, attended to in own home environment, perceived as a great help to self, beneficial for the hospital, provides support, promotes continuity of care and team work and decreases distress of transferring between hospitals. Those two participants who rejected the notion of intermediate care expressed that they felt better when they ask for the services themselves and whilst hospitalised, all their needs were met and hence there was no need for continuity of care.

Intermediate care I think is that care provided at your own home by the hospital until you regain your full strength. (IC8, Daughter).

Participants' knowledge on how to prevent another fall was highlighted and included the following: removal of carpets; being careful whilst walking outside; taking things calmly; wearing properly fitting shoes; using the right walking aids; proper lighting; removing obstacles; walking alone and avoiding slippery shower floors.

I am really careful, because even those carpets may be obstacles, so I need things that grip well ... One has to avoid overdoing things and not getting tired. One has to pay attention where he is walking, and be cautious that there is no water on the floor. (PM1. Peter)

6.3.7 Overview

This section demonstrated the findings on the care pathway from admission until discharge as perceived by patients and their ICs. The results show that whilst they were generally satisfied by the care they/their relatives had received, they did encounter certain difficulties, especially with regard to communication and lack of information-giving. The HCPs' views will be presented in the following section.

6.4 Phase 1: LOOK Phase -Part 3

6.4.1 Description of the HCPs' sample

During the period, April 2013 and March 2015, seventeen HCPs were interviewed during one-to-one semi-structured interviews. HCPs participating in this PAR study represent all members of the Multidisciplinary Team (MDT).

The HCPs sample comprised professionals with various years of experience to include a doctor with two years' experience and a nursing aide with twenty eight years practice in the orthopaedic ward (Table 6.4). The sample also included HCPs from the rehabilitation hospital and from the community nurses.

Table 6.4 Demographic characteristics of HCPs

HCP Number	Status	Gender	Place of interview	Work experience
1.	Nurse	(F)	Acute hospital	9 Years
2.	Nurse			5 Years
3.	Physiotherapist			8 Years
4.	Nurse			3 Years
5.	Nursing aide			28 Years
6.	Nurse			3 Years
7.	Occupational Therapist		Acute hospital (Canteen)	8 Years
8.	Social Worker		Acute hospital	6 Years
9.	Occupational Therapist		Acute hospital (Canteen)	12 Years
10.	Nurse	(M)	Acute hospital	17 Years
11.	Physiotherapist	(F)		2.5 Years
12.	Care worker			11 Years
13.	Consultant Geriatrician	(M)		9 Years
14.	House Officer (second year)	(F)		2 Years
15.	Resident Specialist	(M)		9 Years
16.	Nurse from the rehabilitation hospital	(F)	Rehabilitation hospital	21 Years
17.	Community nurse		Home	18 Years

6.4.2 Results of interviews conducted with HCPs

Four main themes with various subthemes emerged and are presented in Table 6.5.

Table 6.5 Phase 1: Themes and subthemes (HCPs)

No.	Themes	Subthemes
1.	MDT approach as perceived by HCPs	<ol style="list-style-type: none"> 1. MDT collaboration as perceived by HCPs. 2. HCPs' views on team members' roles.
2.	Patients' care pathway as perceived by HCPs.	<ol style="list-style-type: none"> 1. HCPs' perceptions about their role in the care pathway. 2. HCPs' views about patients' and ICs' participation in care pathway. 3. Patients' self-care needs as perceived by HCPs. 4. Patients' pain as viewed by HCPs.
3.	HCPs' views on communication / information-giving.	<ol style="list-style-type: none"> 1. Factors influencing communication and information-giving. 2. Information-sharing amongst the MDT. 3. Quality of information-sharing with patients.
4.	HCPs' views on discharge: Impact & challenges	<ol style="list-style-type: none"> 1. Continuity of care following patient discharge. 2. The discharge process as perceived by HCPs. 3. HCPs' views about community resources and intermediate care.

6.4.3 Theme 1: MDT approach as perceived by HCPs

This theme conveys how each member of the MDT view their role in the care pathway of the older fractured femur patient. Whilst HCPs disclosed concerns about other team members' practices, all perceived the importance of team work.

6.4.3.1 MDT collaboration as perceived by HCPs

HCPs perceived team meetings positively and advantages discussed included the following: it helps in information-sharing about the patients' progress (n=7); enhances decisions about discharge planning (n=3); decisions are made collectively (n=1); to help to understand patients' needs to obtain optimum quality care (n=3); enhances teamwork (n=4) and encourages better coordination (n=1). The OT concluded that MDT meetings provided them with more time for planning the

patient's rehabilitation. The physiotherapist disagreed with the rest of the participants since she recognised a certain lack of autonomy in decision making.

The need for improvement during weekly MDT meetings was emphasized by the geriatrician suggesting that there should be a clear plan about what objectives should be met by the patient for the following week. An OT recommended review of the eligibility criteria since only patients under the care of the geriatricians are included, whereas the other OT suggested better communication between team members. Two nurses talked about the rights of the patient during these meetings, whereas the relatives' presence was further given importance by five HCPs.

HCPs mentioned the inclusion of other members to the team. The OT suggested the speech language pathologist, whilst two nurses and the geriatrician perceived the importance of a pharmacist, the social worker emphasized the importance of a psychologist and a nurse assistant suggested a nurse from the rehabilitation hospital for continuity of care.

The presence of the orthopaedic surgeons was challenged by five nurses and a physiotherapist whereby all claimed that their absence was causing problems with discharge planning, time frames and lack of communication. However, inconsistency in responses was noted between doctors and surgeons, with the junior doctor and the geriatrician agreeing that the surgeon should be included in MDT meetings. They argued that ultimately, discharge decisions are made by the orthopaedic consultant and his/her presence enhances these meetings as sometimes there are issues specifically related to the operation. However, the orthopaedic surgeon explained that he does not perceive that surgeons should be included into MDT meetings since their decisions are more on medical aspects rather than on discharge.

... we decide whether the patient is partial weight bearing or full weight bearing and that's the role of the orthopaedic and that's what he needs to decide. I don't think that the orthopaedic surgeon needs to be that much involved in the discharge planning. (HCP15, Doctor).

Additionally, eleven HCPs shared that the charge nurse should coordinate meetings and update the team. There was consensus on this notion and four HCPs explained

the rationale for their choice which included: the nurse is well-informed about all the patients; when there are difficulties the charge nurse is immediately consulted and the nurse is a link between the doctor and patient during the consultants' ward round. This statement further described the importance of the nurse leading MDT meetings.

I see the nursing staff as being the patients' best advocate because they are present all the time and they are the ones who can coordinate the input from all the different specialists whether it is an input from a physiotherapist or from a doctor ... or input from the theatre or ... from the surgeon. ... they should take a lead role in coordinating the care of that patient. (HCP13, Geriatrician).

In contrast to this, two nurses claimed that doctors should give more information to the team, whilst another nurse pointed out that each member should act according to his/her function. Moreover, half the participants stressed that, apart from the nurse, it is the duty of each and every team member to inform each other because patients discuss their concerns with various HCPs.

6.4.3.2 HCPs' views on team members' roles

A nurse and an OT talked about how they viewed the surgeons' role as being concerned mainly with the patient's medical condition, rather than viewing the patient holistically. Nurses compared the surgeons' role with that of the geriatricians by perceiving that holistic care is demonstrated more by these specialists. Nurses noted that geriatricians spend more time with the patients during their ward rounds.

The consultant who would have admitted the patients to our ward will be more concerned about their wound, but the holistic care would be provided by the geriatrician. (HCP1, Nurse).

HCPs commented on the trust each team member has when it comes to discharge decision-making by team members expressing freely their views on patient discharge. Nurses commented that, prior to discharging a patient, the orthopaedic surgeon consults with the other team members and decides according to their feedback. Conversely, an OT explained that she felt like an 'outsider' to the team, especially by the medical profession:

It's because we are not on the ward all the time, we seem to be non-existent, then you go and ask them about someone, they just give you an answer and that's it. (HCP9, OT)

6.4.4 Theme 2: Patients' care pathway as perceived by HCPs

HCPs perceived that their roles start immediately upon admission by a thorough physical assessment to identify problems with the care pathway. The majority described their roles in relation to physical aspects, a few others considered the social aspects. Very few mentioned the psychological or spiritual aspects in care.

6.4.4.1 HCPs' perceptions about their role in the care pathway

Nurse/assistants (n=6) talked about how, on admission, they assess the patient for the cause of fall, pain, indication of pressure sores, social and communication problems or difficulties with swallowing. Nurses perceived their role as important because they try to identify problems, whilst ensuring the best possible outcomes.

We check if s/he has been admitted from home with a sore or what type of skin the patient has – whether it is dry. We also see if the patient is dehydrated. Then we check the feet. ... I also check if the patient can communicate and if he has difficulty in swallowing (HCP5, Nurse Assistant).

The geriatrician ensured that the patient is fit for surgery, whilst the physiotherapists and OTs on admission draw up a detailed assessment on the pre-fracture mobility status and previous level of independence to plan achievable goals. The social worker also talked about her assessment of the patient, including any remaining disability, living condition and home support. All HCPs further explained that assessing the patients' previous pre-fracture mobility status was fundamental so that they could start planning the rehabilitation process. Four nurses also explained that on admission they discuss the support available at home with the patients and their ICs. A nurse considered that it is important to assess the patient discharge destination with other team members on admission since she claimed that, in practice, the majority of the team starts discharge planning once surgery is performed.

Generally, the majority start thinking about discharge destination post-operatively, not on the first day. (HCP4, Nurse).

When asked about their role in caring for fractured femur patients, nurses prioritised promotion of independence, assisting the patient with ADLs, prevention of complications and enhancing patient comfort. Doctors acknowledged that they wanted to ensure that a proper diagnosis was made, their patients were medically stable and as with the nurses, they ensured that their patients were pain free. The physiotherapists and the OTs focused on mobility and maximisation of self-care as early as possible so that patients would regain their previous level of independence. The majority of HCPs described their role in relation to the physical perspective whilst two nurse care assistants talked about patient empowerment.

... we try to help him and make sure that the patient is comfortable in bed. Obviously, he will not return to his previous state overnight, but I think with some therapy, he would improve. You always try to empower him so that gradually he will return to normal (HCP12, Care Worker).

Interestingly, an OT talked about how she looks at the patient holistically and aims to be patient-centred, whilst the other OT considered that rehabilitation in the older patient may be influenced by fear of the unknown and pain.

Our role as an OT on the patient is patient-centred, so it is very important that everything is surrounded around the patient, so it depends on what they need, what their abilities are, so everything is involved around the patient. (HCP7, OT).

There was evidence that the physical aspect controlled the HCPs' role. Commonalities identified with regards to perceived roles were that nurses and doctors (n=6) explained that their role is: to check that the patient is fit for surgery; to check the patients' blood investigations; to ensure blood availability; to assess the wound and to ensure that the patient is haemodynamically stable. Two nurses stated that they observe the patient's general condition and progress, whilst another prioritised teaching over mobility. The physiotherapist explained that postoperatively their role is to mobilise the patient, where they help the older patient to gradually decrease dependency upon them. HCP14 commented that as a doctor, her role is to make sure that the patient has the necessary support at home following discharge.

The surgeon affirmed:

I see patients in Casualty if they have a fractured femur I will make sure that they have the appropriate X-rays and the appropriate investigations, appropriate blood tests. I make sure that they are correct and that they are good and then admit them in the ward, see them accordingly until the operation is done. Sometimes, I do the operation and care for them after in the postoperative period. (HCP15, Doctor)

With regards to the HCPs' role regarding psychological aspects in the care pathway, participants had to be prompted. However, doctors varied in their responses with the geriatrician acknowledging that although they were trained to take care of the patient holistically, they give more priority to medical and physical needs. The orthopaedic surgeon shared the same views, by acknowledging that little attention is given towards the psychological aspects, although if there is a psychological problem, they try to address it. The doctors confirmed that more attention is given to the social aspects in the care pathway of a patient.

From my end if it is a very obvious case, if there is a psychological problem, one would help, one would try to address it but we don't really ...give much thought to that, unfortunately, I might say. Socially, yes, we ask a lot. We ask about social problems and if the patient is not cared for we have to plan accordingly. (HCP15, Doctor).

As with the doctors, all nurses had to be prompted about the psychological aspects in the care pathway. However, they expressed that their role included: patient reassurance through information-giving encouraging patients to talk about their fears and exploring patients' psychological needs. Only one nurse acknowledged the importance of psychological care and that the lack of time for communication seemed to be a hindering factor in providing appropriate psychological care.

The social aspects were less frequently mentioned by the nurses (n=3), whereby they discussed that their role is to examine whether the patient has a family, what support is available or whether there is need for social worker input. The community nurse disclosed that her psychosocial role was maintained by looking at the patient holistically, ensuring that there is good understanding of the condition, whilst considering that the ICs have a central role in providing support to the patient. The

physiotherapists stated that they discuss psychosocial issues with the MDT, whilst the OTs perceived their psychosocial role as being an assessment of how much support the patient has at home. The social worker emphasized that her role is to view the patient holistically and not only consider the medical problem, whilst ensuring that the patient is discharged safely home with minimal problems.

... sometimes a patient might be living alone and he has no social support. We have to see if the home environment is conducive to living ... A holistic approach which includes the physical, the social and even the psychological is important. The patient may be suffering from depression and would need psychiatric help ... it is very important that not only the medical side is given importance but the patient as a whole. (HCP8, Social Worker).

Discussing HCPs' view on their role in spirituality, most of them acknowledged that minimal attention is given to these needs. All nurses stressed that they call the chaplain if the patients request it specifically, or if patients' condition deteriorates. A nurse / assistant discussed that they assess the patient religious beliefs on admission. The nursing aide conveyed how HCPs do not give priority to the spiritual needs of the patients. She also mentioned how the duty of care exceeds the patients' need to spirituality and highlighted the different practices of patients with different religious beliefs. HCP5 saw her role as important when it comes to praying with patients.

If one is reciting the rosary, and we want to change his position in bed, we take the rosary beads, we put it on the bedside table and we tell them 'You'll continue later, please.' (HCP5, Nurse Assistant).

Interestingly, the nurse explained that the rehabilitation hospital policy is that all patients admitted will receive the anointment of the sick. Furthermore, the community nurse noted that spiritual care is crucial because unnecessary stress can be caused if these needs are not met.

Anxiety is a major aspect, consider a patient who goes to Mass every day, it's a change, for the patient so one must contact the parish priest. There are Djakonija services today ... someone can come and maybe he needs confession, someone who comes and visit (HCP17, Community Nurse)

Three doctors explained that neither they, nor the hospital as an institution considers patients' spiritual needs. The two physiotherapists perceived that spirituality is something personal to patients and is not part of their role, whilst one talked about how she motivates patients by telling them that they can go to church if they climb the stairs safely. Both OTs viewed spiritual care as important but one of them described that although spirituality was included in her training, she felt limited on how to put the theory into practice, since it is not incorporated much in her work.

6.4.4.2 HCPs' views on patients' and ICs' participation in care pathway

Findings revealed that decisions on the care pathway are taken in advance, whilst others believed that patients and their ICs are always involved, especially in the discharge process. Some argued that decisions are influenced by the hospital bed management system, whilst other HCPs acknowledged the medical dominance. Three nurses stressed that occasionally, ICs decide on behalf of the patient by requesting institutionalisation.

The consultants and we as nurses are aware that we should involve the patient and their relatives in any decisions taken for the welfare of the patients. There are also many occasions when the relatives themselves discuss with us their concerns and we do our best to help them. But we are very apprehensive about this because of the fact that consultants decide that a patient is going to be discharged that same day and also because of bed management and problems at the acute hospital (HCP6, Nurse).

Five HCPs perceived that patients are included in decisions about their care pathway, provided they were cognitively fit. Although the physiotherapist and the geriatrician acknowledged that improvement is necessary to include the patients and ICs in decision-making, both stressed that they do discuss discharge decisions with all involved. Also, two doctors described that patients and ICs are not involved in decisions related to type of operation, but decisions are led by the injury itself. Doctors felt that they do involve patients and ICs in discharge planning process.

In type of care not that much, like in the type of operation that is needed we don't involve the relatives but then in discharge planning we do involve the relatives ... (HCP14, Doctor).

The OT acknowledged that although they try to involve patients and ICs, decisions are taken abruptly. The OT and social worker stressed the importance of inclusiveness because ultimately, the patient decides the discharge destination. They continued that sometimes it is imperative that decisions are taken by HCPs. There are times when the system is abused or advantage is being taken of the situation.

But then there are others where we have to take the decisions ourselves. Because even though we believe in client-centred care, and I am sure that this is an important area, there might be some who abuse of this situation. This means that with a little support, the patient could be taken care of, but relatives might come up with all sorts of excuses to leave the patients in hospital up to a certain time. (HCP9, OT).

Nurses (n=5) valued ICs' involvement during patient admission, whilst doctors perceived that ICs are definitely involved when the patient's condition deteriorates or the patient is not fit for surgery. A nurse stressed that family involvement is beneficial to the patient, irrelevant of the patient's age. Also, the physiotherapist specified that the more the ICs are involved in the care pathway, the more the patient complies with their instructions.

Usually, we start involving them from [the] first day postoperatively or when the relative comes with the patient on admission, because we start asking them questions, for example about stairs, about the need to wear proper footwear, things like that we need them to bring, which means the relatives help us. I think we do involve them. (HCP3, Physiotherapist).

Further findings revealed that ICs do involve themselves, especially on discharge decisions. However, nurses argued that the problem occurs when the patient and ICs disagree amongst themselves with the patient refusing institutionalisation, or when they both oppose the doctors' decision. HCPs recalled that this usually occurs when there are patients who are fit for discharge to their home but they refuse and ask for further rehabilitation.

The OTs identified two types of ICs: there are those who are over-protective and hence, instead of helping, impede recovery and there are those who mean well for the patient but hinder the patients' abilities to regain independence by requesting institutionalisation for the patient.

Finally, the geriatrician valued the involvement of ICs, especially on admission to identify ICs plans and assesses their willingness to support the patient and to make clear plans together. The geriatrician continued that difficulties come with frail older patients who are dependent upon their ICs, since healthier patients are less dependent and are capable of taking decisions. However, the geriatrician was unsure about how far ICs are involved at the acute hospital in general.

6.4.4.3 Patients' self-care needs as perceived by HCPs

HCPs generally considered that the promotion of self-care was an important issue in patient care. Two nurses and an assistant perceived that when a patient attempts to be self-caring immediately postoperatively and thinks about discharge, s/he recovers more quickly. Nurses and the geriatrician mentioned patients who select institutional care because of lack of social support, patient cognitive impairment due to dementia, multiple co-morbidities and frailty which may limit their ability to recover fully. The OTs perceived the use of equipment as vital for promoting self-care. They explained that when they are advising patients, they keep in mind continuous patient progress, the aesthetic part and the need to use equipment in the long term.

HCPs remarked that although patients are discharged, they still require assistance with food preparation, ADLs, mobility and home adjustments. The surgeon stressed the need for a safe environment where patients can be observed, ideally without multiple floors, in which case they should use a stair lift, so that mobility is enhanced. The physiotherapist and community nurse discussed the need of encouragement and someone to help following discharge.

If the patient lives alone, he shouldn't be discharged till he is hundred percent fit, and some help also has to be provided. Because until he starts walking normally, imagine that the patient needs to wash his clothes, it wouldn't be easy and moreover if s/he needs to get out of bed during the night to use the bathroom, he might fall again. (HCP5, Nurse Assistant).

6.4.4.4 Patients' pain as viewed by HCPs

Nurses perceived pain management and patient comfort as a priority in the rehabilitation process. Two nurses stated that they liaise with doctors to ensure that adequate pain relief is prescribed for discharge. By contrast, another nurse perceived

that HCPs give more importance to pain relief in the acute phase because once the patient is discharged, it usually decreases. With regard to the physiotherapists, they perceived pain relief as important because it hinders patients' mobility. The OT discussed misconceptions about pain relief amongst older patients. As an example, some believe that it is better not to take pain relief medications and try to bear the pain while others think that since surgery is over, they should be pain free.

Yes, you try to make them as comfortable as possible even prior to the operation. I think we focus more on pain control, once the patient is here in hospital. Once he leaves, it seems that the pain has subsided a lot. (HCP6, Nurse).

6.4.5 Theme 3: HCPs' views on communication / information-giving

This theme captures the factors enhancing and hindering the communication between the older fractured femur patients and HCPs. It also depicts what and with whom HCPs share information.

6.4.5.1 Factors influencing communication and information-giving

Factors influencing communication were: lack of time (n=8); shortage of staff (n=7); increase in workload or hectic ward (n=7); hearing problems (n=2); language problems and speech difficulties (n=5); pain (n=2); noisy environment (n=1); problems with cognition (n=4) and dementia (n=3). The hospital on call system was perceived as a major hindering factor in communication by the OT.

Sometimes we are in such a hurry that you have to do everything at one go. For example, the pager is a very important thing, but I might be attending to a patient, and when it rings, I have to answer it otherwise it might seem that you're not doing your work. ... you have to explain to the patient that the call was something pertaining to hospital, and not something unimportant. There is also lack of time and staff. (HCP9, OT).

Lack of time for communication was perceived by the geriatrician as a problem in that relatives are often busy at the time when geriatricians are available. Remarkably, nurses and two doctors discussed the use of medical jargon, whilst another nurse viewed patient attitudes or the nurse being unknowingly judgemental as hindering factors with patient communication. The social worker added that the hospital

environment is not conducive for confidential discussions with patients, particularly if the patient has hearing difficulties.

The thing that affects us most is confidentiality, because you cannot take a patient to another room. On several occasions you have to speak loudly because the patients will not respond. This really annoys me and about which I don't feel comfortable about. (HCP8, Social Worker).

Nurses perceived that a factor which enhances communication is family involvement as important information on the patient's health can be obtained. Two nurses and the OT commented that the nurse-patient relationship, encouragement, empowerment and honesty were other factors enhancing communication. The nurse at the rehabilitation hospital emphasized the importance of building nurse-patient relationships which can be achieved by HCPs, by spending time near the patient:

We try to communicate with the patient especially when assisting with bed bathing and I try to ask basic questions to start a discussion on how they intend to continue with their way of living once they are discharged. (HCP2, Nurse).

6.4.5.2 Information-sharing amongst the MDT

HCPs share information mostly on the patient progress, nutrition, pain management, mobility, discharge plan, ADLs and home support. A nurse expressed that she shares information mostly with the doctors, whilst exchange of information is more focused on patients' needs rather than on patient progress.

I think we only share information about the present needs of the patient. Unfortunately, the progress of the patient is taken for granted (HCP2, Nurse).

All participants emphasised the importance of a multidisciplinary approach and each professional discipline conveyed a different perspective in the patient care pathway. When it comes to information-sharing with HCPs, participants frequently mentioned the doctors. A doctor explained that he shares information with his colleagues according to patients' medical needs. However, he acknowledged team effort and claimed that the involvement of other HCPs is vital. For example, when there are

social problems, the role of the social worker is essential. Similarly, the social worker explained that although she discusses issues with the patient, she is more likely to share information with the doctors, especially when it comes to sharing confidential information concerning patients' well-being.

It seems that information is shared according to the needs required at the time. To illustrate this, the physiotherapist revealed that she shares information with the nurses, especially when there are immediate patient physical needs (pain or fainting), whilst some nurses (n=4) stated that they share information with doctors. Other nurses share information with physiotherapists, with the OTs and with the social worker. Both nurse assistants explained that they only share information with the nurse caring for the patient. A nurse explained the difficulties she encounters when communicating with other HCPs, such as no on call system for the speech language pathologist and nutritionists. The OT commented that she mostly shares information with doctors, physiotherapists and nurses. Finally, the doctors commented that all the roles of each member of the multidisciplinary team are important. Whilst some are focused on patient care, others focus more on the discharge process.

Especially in orthopaedics, you have to involve the physiotherapists. They're important and even the occupational therapists and the nurses who are taking care of the patient, post procedure for the rehabilitation and then OTs and social workers do plan the discharge for rehabilitation. I try to involve everyone and communicate with everyone to see what's best for the patient. (HCP14, Doctor).

Therefore, there was a variety of views about the factors influencing the information-sharing process amongst the MDT. A nurse and a care assistant discussed ethical notions in relation to information-sharing, by commenting that confidential issues should not be shared with the MDT unless it is dangerous to others. The social worker remarked that although she needs to abide by data protection and confidentiality, the patient's well-being takes precedence.

The community nurse observed that doctors' illegible handwriting often caused problems. Also, on discharge, discrepancies regarding treatment instructions between the nurses' written handover and the doctor's instructions often causes some

confusion. The problem with legibility in documentation was discussed by a nurse and a doctor and emphasis was placed on the importance of verbal communication. The OTs also expressed their concern about communication problems with information-sharing amongst the MDT, as sometimes they receive minimal or unclear instructions. The OTs emphasised that the equality between team members and team work is crucial, even though each member has different goals to reach. The community nurse suggested that a possible solution to enhance information-sharing amongst colleagues would be to create a virtual closed group, where community nurses share any difficulties they encounter.

6.4.5.3 Quality of information-sharing with patients

Nurses and their assistant (n=3) talked about the information they give to the patients including: the need for operation, information about physiotherapy and on the rehabilitation hospital. A nurse stressed that she gives priority to the rehabilitation process and informs patients about what to expect when they are transferred there. The physiotherapist described that on admission, she informs patients and their ICs what is expected from them, what exercises they need to do, the importance of wearing proper footwear and what mobility aids they need. A care assistant emphasized that the patient's nurse should explain in detail, i.e. prior to the operation, about the need for surgery, the importance of physiotherapy postoperatively and feedback should be obtained. A nurse stressed:

Primarily, we would tell them that they have been admitted to hospital because they need an operation. We would also tell them that some physiotherapy would be started here, but when the patients are better they would be sent to the rehabilitation hospital where they would be helped to regain their independence (HCP10, Nurse).

6.4.6 Theme 4: HCPs' views on discharge: Impact & challenges

HCPs shared how they prepare the patient for transfer to the rehabilitation hospital in a short period of time, whilst ensuring that the right information is communicated for continuity of care purposes. Factors influencing discharge and information-giving were discussed by HCPs.

6.4.6.1 Continuity of care following patient discharge

HCPs explained that upon patient transfer for continuity of care purposes, information is shared by writing a handover on the patients' case notes. Nurses also complete a continuity of care form, they call the ward to share patient information and provide the rehabilitation ward with the patients' notes and discharge letter. The physiotherapists explained that they give a verbal handover to their colleagues only when encountering a complicated case, whilst the OTs share verbal information when advice to patients on home adjustments was given. A nurse explained:

Well, I cannot think of any reason why we shouldn't communicate with those who will be in contact with the care of the patient, no matter where the patient will go after discharge from hospital even in the community. We need to do hand over and communicate ... I don't think anything should interfere with our sharing of information. (HCP2, Nurse).

Moreover, nurses, OTs and physiotherapists commented that the hectic level of activity on the ward, lack of time, lack of communication and unclear discharge planning all hinder proper handover upon patient discharge.

Emphasis was also placed by the geriatrician about continuity of care by following the discharged patients, with the aim of assessing coping and adherence with the appropriate medications, such as bone protection. For continuity of care purposes, the geriatricians should ensure that verbal information is given to the patient and that information is included in the discharge letter. Another doctor commented that when a patient needs to be followed by a GP, documented information is given for clarity and continuity of care. From the physiotherapists' and OTs' perspective, a follow-up appointment is dependent upon whether patients need further therapy. Finally, nurses emphasized the importance of continuity of care when patients are discharged and they can go home. Communicating with community nurses whilst providing them with documented information was deemed to be very important by the ward nurses.

6.4.6.2 The discharge process as perceived by HCPs

HCPs perceived the discharge process as an unplanned and stressful event for the patients. The geriatrician viewed the current discharge process in the traditional way as very much doctor-led, whilst the surgeon suggested further improvement since it

is not a seamless process and there is a long wait for the rehabilitation hospital. A doctor and nurse assistant acknowledged that discharge planning should start on admission, whilst they perceived the social worker's role as crucial in assessing the patient's social situations. In contrast, another doctor viewed it as an organised MDT approach when compared with other wards. Providing patients with an expected discharge date was perceived as important by the rehabilitation nurse, since it helps in the planning and preparation of the home environment.

I think that the best thing is that from admission we should prepare them, for example, the social worker should ask the patient with whom s/he live and tackle any problems that the patient might have from the day of admission before the operation, not after ... (HCP5, Nurse Assistant).

The physiotherapist explained that some patients are discharged to a private rehabilitation hospital against payment or through a public/private partnership scheme. HCPs also described the public perceptions about a compulsory transition period to the rehabilitation hospital, despite the medical team decision.

And the general public perception is that after the acute hospital, they would be sent to the rehabilitation hospital and then home. Even when you can see that a patient is independent, you wonder why he has been kept in hospital because s/he is so good that s/he need not be sent to rehabilitation. (HCP9, OT).

HCPs talked about inadequacies in the current discharge process being: lack of information prior to discharge; late evening transfers to the rehabilitation hospital; lack of information at the rehabilitation hospital and no orthopaedic discharge guidelines. Factors hindering the process were: lack of discharge planning; unanticipated discharge; lack of home support; lack of time; pressure on hospital beds; shortage of staff; general condition of the patient and misinformation about care pathway and rehabilitation. A recurring topic within this theme was that the orthopaedic consultant decision is a major influence on patients' discharge.

We have consultants who prepare us and tell us that, for example, in two days' time, the patient will be discharged from hospital. There are others who inform us on that same day that the patient will be discharged and this means that you cannot prepare them in one day. (HCP1, Nurse).

HCPs (n=10) emphasised the importance of communication amongst the MDT whilst acknowledging that haphazard transfers cause anxiety and shock to the patients. Also, nurses felt that it is a stressful situation when they have to transfer the patient unexpectedly. The majority of the HCPs acknowledged that there is a lack of information during the entire process. The difficulty with unexpected discharges was viewed by the OTs as very problematic. Delayed involvement of members of the MDT was described as a hindering factor by the social worker and the OT.

Something that annoys me is that sometimes we have a referral or discharge on that same day practically that the patient is going to be discharged. (HCP9, OT).

The nurses' narration reflected the need of reassuring the patient by informing the relatives about the patient transfer and by clarifying any patient's or IC's concerns following doctors' discharge advice. Two nurses prioritised patient safety, whilst only one nurse stressed the importance of handover to ICs. Patient confidence in self and ability to cope was viewed as important for the community nurse prior to termination of their service. The surgeon discussed ensuring that the patient is medically fit, stable with mobility, as well as listening to the MDT's views about a particular patient, as important aspects when it comes to discharging a patient. Furthermore, all HCPs stressed the importance of education on fall prevention.

I also tell them to remove any carpets and to put on well-fitted shoes. Even that they should be careful if they have pets around them because they might trip in them since they are not steady at all. Well, even when they go to the bathroom they have to be careful not to fall or to wet the floor and even to dress, they should sit down. (HCP5, Nursing Assistance).

Four nurses mentioned that upon patient discharge, they give information on various aspects such as: medications; wound care; removal of sutures; footwear; follow-up appointment; healthy eating; self-care and mobility. Two nurses thought it important to inform the patient about their stay at the rehabilitation hospital and about the available community services. Two nurse assistants viewed their role as important in psychologically supporting the patient for the transition between hospitals.

All HCPs felt that each team member gives information according to one's professional role. Doctors, nurses and OTs acknowledged the need for improvement in information-giving prior to discharge. The geriatrician expressed that he gives verbal information on compliance with treatment for osteoporosis. Also, a doctor stated that she gives information based upon the discharge summary and recognised the need for more information and psychological support to those patients being transferred to the rehabilitation hospital. In this study, the surgeon commented that he generally focuses his information-giving on follow-up appointments and on pain relief. The rehabilitation nurse explained the importance of involving the pharmacist in the discharge process.

I tell them if you have any queries you just inform us. The pharmacist here (rehabilitation hospital) writes up a form with pictures for the patient on discharge with the clock and it is written. For example, if it's Burinex there is the reason why the patient is taking it. (HCP16, Nurse).

The HCPs noted that when discharging a fractured femur patient, they focused on: patient safety (n=5); medical condition (n=4); compliance with medications (n=3); prevention of falls (n=3); ability to mobilise safely (n=4) and wound healing (n=2). Two OTs and the social worker prioritised patient safety and good social support prior to agreeing with patient discharge.

You have to see that the patient is stable. That is the most important thing. You have to see that postoperatively you followed him up correctly, the patient spent the right amount of days under observation and all the tests were satisfactory. But then we also need to consider his social aspect, [you] need to know where you are going to discharge the patient because you don't want to discharge him just to discharge him home and that's it. You see whether he needs further rehab, further physiotherapy mobility wise, whether there is potential for further improvement. (HCP14, Doctor)

The geriatrician and a nurse assistant talked about the patients' often upsetting experience waiting for hospital transport. The physiotherapist, the OT and social worker emphasized the need to inform the patient what to expect from rehabilitation and that although the environment is different, they would receive care which is more focused on rehabilitation.

When they are being sent to the rehabilitation hospital, this means that they are being sent from one hospital to another. Their reality is different, from one to the other. Ideally, they should be informed about the environment and care given to them there. (HCP11, Physiotherapist).

Various methods of improving the discharge process were suggested by nurses (n=4), physiotherapists and a doctor who recommended a clear discharge plan. They continued that older patients should be given written information, including information on healthy eating, mobility, proper footwear and wound care. The geriatrician suggested that an information booklet should help outline the expected care pathway, explain the expected outcomes, state who the team members are and the options available for their rehabilitation. He recommended that information should be very open and not prescriptive, because not everybody requires the same information. HCPs noted that written information is a good source for patients because if they forget, they have something to refer to. Another doctor outlined what information such patients required and mentioned that it should include a description of a fracture, some information on pain management and the healing process. It should also describe what to expect from rehabilitation.

You explain to the patient what type of treatment he needs, how to take care of the wound, and when the sutures are removed, how to walk. These are all questions that the patient asks. It might be necessary to write the information down or even give the patient some leaflets. (HCP1, Nurse).

The rehabilitation nurse recommended continuous evaluation on the entire care pathway, through an anonymous questionnaire. Two HCPs recommended family training sessions with the MDT. Another nurse suggested:

I like that things would be taken more seriously, considering that if the patient was my own mother, I would give her the optimum care even in relation to discharge planning. We also need to be non-judgmental saying, he/she does not want to take care of her. We have to abolish such judgments and be more realistic even with the relatives (HCP2, Nurse).

6.4.6.3 HCPs' views about community resources and intermediate care

HCPs were mostly aware about community nurses, although only one was aware about handyman and incontinence services (Appendix 34). The community nurse

explained about the existing communication between the community nurses and the hospital system whereby she refers patients to hospital specialties, for instance referral to the tissue viability unit. The physiotherapist added:

If a home visit is required we contact CommCare where there is a physiotherapist and that physiotherapist goes to a home visit with an OT. (HCP4, Physiotherapist).

The OT commented that the difficulties within community care are limited community services and the lack of human resources. She shared her difficulty when it comes to suggesting these services to patients, since there is a waiting list for some services. The social worker explained her role which included: providing assistance when there are problems with discharge and explaining the application process for the required community services. The social worker clarified:

If the patient has a certain fear of going home and is reluctant to do so, or if, for example, he tells us that he has no one to take care of him, we try to apply for a nursing home, even a temporary one, or we apply on his behalf for the adequate services that he might need. We explain to him that there is home help, meals on wheels and telecare. (HCP8, Social Worker).

Nurses and care assistants emphasized the need for education amongst older patients since they do not abide with instructions, such as, wearing the telecare help button. The need for more awareness about the available community resources was discussed by HCPs. They suggested more community-based rehabilitation services, early support discharge schemes with MDT visits, night shelters and an increase in available community resources, for example, home help or meals on wheels.

A lot of patients require help with personal care, with meal preparation and particularly people with problems of incontinence but then the services that are available are not enough many a time to enable a person to go back home but if there were more of these services, I think we would manage to discharge more people home and reduce the number of people going to institutional care. (HCP13, Geriatrician).

When HCPs were asked to define the term 'intermediate care' six HCPs did not define the term since it is a new concept. The others defined intermediate care as the

phase from time of discharge until the patient becomes independent and others defined it as some type of middle care, as the care between the hospital and home. The geriatrician defined the term as a setting outside the acute hospital which serves as a bridge between the community and the acute care.

All HCPs perceived some advantage including: helping patients remain in their own environment; decreasing hospital length of stay and avoiding hospital-acquired infections; providing home care; enhancing continuity of care and possibly increasing independent living. Other HCPs commented that intermediate care decreases bed shortages in the acute hospital, decreases readmission rates, patients' complications are detected earlier, decreases institutionalisation rates and patients feel reassured that someone who following their progress until their next appointment. The physiotherapist and OT commented that setting this up would require financial and human resources.

The orthopaedic surgeon observed that intermediate care would keep patients in the community. The geriatrician (HCP13) also stated that the rehabilitation hospital is already functioning as an intermediate care facility and a geriatric hospital. He commented that there are certain patients who need some assistance for a short period of time. Therefore, the introduction of intermediate care would decrease beds at the rehabilitation hospital.

I think then sometimes there are a few patients who more than rehabilitation as such, need a period of recovery, especially, if they live alone. They might be wary of going straight back home alone and maybe having an intermediate step may be where they can be able to recover before going home might be helpful. Unfortunately, there is a big pressure on, even on the rehabilitation hospital, there is not enough services and not enough beds available for everybody (HCP13, Geriatrician).

6.4.7 Overview

This section discussed the themes and subthemes which clearly emerged on the care pathway from admission until discharge as perceived by HCPs. Findings revealed a lack of information during the patient journey.

6.5 Phase 2: THINK Phase

As mentioned above, the main findings of Phase 1 illustrated a serious lack of information-giving whilst patients with a fractured femur were in hospital. This was further supported through the various informal communications held during Phase 2 (Appendix 15) and hence a patient information booklet was devised in response to these findings. (Appendices 16 & 17).

During the various informal communications held with the participatory action group (PAG), the research facilitator discussed the three month quantitative data in this THINK phase. This data provided the group with important information on the patients' hospital length of stay and discharge destination. It was discussed that most of the patients were discharged to the rehabilitation hospital whilst only 18% were discharged home. All HCPs expressed that as a team, self-care needed to be enhanced so that patients will go home directly without the need for rehabilitation.

Although, the key discussion was mainly focused on the need for more information, participants discussed lack of involvement in decision-making and communication issues.

During this phase, the HCPs in the PAG also talked about person-centred support for individual patients and their families and not one size fits all. Most discussed that there was a need to get the basics right first and relatives should be signposted about the available resources prior to discharge. The people should be asked what they want and should be continuously involved since they know best. They revealed that this could be achieved by continuous information and communication.

The patients in the PAG talked about their satisfaction with care but they discussed problems with communication which were related mainly to either the hospital system or to the HCPs. The two patients and their ICs talked about the importance of prevention of falls in the risk population, as well as optimising bone health.

6.6 Phase 3: ACT Phase

6.6.1 Description of Phase 3

Phase 3 of the PAR Cycle focused on stakeholders' views on the patient information booklet describing the care pathway. Data was collected through one-to-one interviews with patients and their ICs and through two focus groups with HCPs.

6.6.2 Stakeholders' demographic characteristics

Semi-structured interviews (n=10) were conducted with fractured femur patients and their ICs after distributing the information booklet. Two ICs were unable to keep the interview appointment. Table 6.6 represents the characteristics of patients and ICs.

Table 6.6 Demographic characteristics of patients and their ICs

Number	Gender	Age	Place of interview	Interviews with ICs
1.	(M)	67	Hospital & Rehab	n.a.
2.	(F)	66	Home	Husband
3.	(M)	70		Wife
4.	(M)	83	Rehabilitation	Wife
5.	(F)	72	Hospital	n.a.
6.	(F)	80		Son
7.	(M)	70	Home	Wife
8.	(F)	93		Daughter
9.	(M)	65	Hospital	Wife
10.	(M)	74	Rehabilitation	Daughter

Two focus groups (n=8, n=6) involving HCPs were conducted including various members of the MDT (Table 6.7). The HCPs participating in focus group discussions were the same HCPs contributing in Phase 1. Each patient and IC was given a number from one to ten (Pt1 / IC1) whilst HCPs were identified by Focus group number and profession (FG1. Nurse, FG2. OT).

Table 6.7 HCPs participating in focus group discussion

Focus Group One (n=8)	Focus Group Two (n=6)
<ul style="list-style-type: none"> •Two nurses •One care worker •One consultant geriatrician •Three physiotherapists •One orthopaedic surgeon 	<ul style="list-style-type: none"> •Three nurses •One nurse assistant •One care worker •One occupational therapist

6.6.3 Results from the interviews and focus groups

Following data analysis, three themes and a number of subthemes emerged and to avoid repetition, all stakeholders' findings were presented together. These are presented in Table 6.8.

Table 6.8 Phase 3: Themes and subthemes of all participants

No.	Themes	Sub-themes
1.	Communication and information gaps in the care pathway.	<ol style="list-style-type: none"> 1. Importance of communication and enhancement of self-care. 2. HCPs' role in reassuring patient through information-giving. 3. Not knowing what to expect.
2.	Participants' views on the information booklet.	<ol style="list-style-type: none"> 1. Perceived problems of using the information booklet. 2. Perceived benefits of using the information booklet. 3. Ease of use and presentation of the information booklet. 4. Suggestions for improvement on the information booklet. Supporting information booklet with verbal information-giving.
3.	Measures taken by patients / ICs after reading booklet.	<ol style="list-style-type: none"> 1. Increased awareness on fall prevention. 2. Patients' and their ICs' use of the information booklet.

To enhance the discussion and review the problem, two case scenarios were presented to HCPs. The findings that emerged in the first theme addressed the identified problem but HCPs mainly focused on the use of the information booklet.

6.6.4 Theme 1: Communication / information gaps in care pathway

This theme conveys issues which emerged at the beginning of the focus group discussion with HCPs, whereby they explained how they often fail to identify themselves to patients. This depicts the importance of communication amongst HCPs in promoting self-care. Moreover, patients and their ICs revealed they were unaware of what to expect during their stay. Consequently, they suggested that the information booklet should be handed to them on admission.

6.6.4.1 Importance of communication and enhancement of self-care

HCPs talked about how emotional issues were occasionally underestimated by professionals, whilst for patients these issues were considered as major concerns which causes them unnecessary anxiety. Another issue, discussed by HCPs and which was identified in the Phase 1 by the patients was the lack of information-giving on the care pathway, lack of involvement in the decision-making process and communication issues.

They barely included the patient in his own decision-making and they did not allow him time to absorb what is happening. Everything had to be carried out in a rush. For example, referring to what a patient said, he was not given time to inform his relatives preoperatively. These are truly minor issues for us, when comparing them to other things which we must take care of, however such things mean a lot for the patient. (FG2. Nurse).

HCPs discussed how they failed to introduce themselves to the patients, even though they acknowledged it as an easy process. However, they acknowledged that it is the patients' right to know who is taking care of them. A physiotherapist explained:

The patients don't know who we are ... that you're a doctor and you're a nurse. There are a lot of different uniforms too. Or uniforms that are the same but people with different jobs ... phlebotomists have the same uniform colour as physiotherapists. (FG1. Physiotherapist).

HCPs in both groups discussed the lack of communication amongst the MDT. They conceded that inconsistencies in care and advice confuse the patients. Nurses, nursing assistants and OTs revealed that patients need consistent care whilst they acknowledged cultural variations when it comes to independency in self-care.

HCPs divulged that Maltese patients tend to depend more on HCPs when compared to foreigners. Patient encouragement in self-care was viewed as part of the MDT role.

Unfortunately, we encounter a lot of these situations. The patient can manage in the shower and the following morning she tells you that she has been bed bathed. I can understand that sometimes promoting independence can be difficult when you have high turnovers. (FG2. OT)

A nurse assistant added:

I think that we Maltese people have a tendency to depend on others. If I pay my taxes, you need to help me. The foreigners try to make a lot more effort. I noticed this even when it comes to mobilisation after the intervention. (FG2. Nurse Assistant).

Interestingly, another issue with regards to culture was raised by two nurses who discussed that older patients are accustomed to regarding the doctors as the experts, so it is acceptable by some that doctors make decisions. The physiotherapist disagreed with the nurses and emphasized that patients need someone to decide because patients and ICs are not familiar with how the hospital system works.

We have to talk about our culture as well. We got taught once we entered hospital that we have to leave everything in the hands of the doctors because they're the experts. (FG1. Nurse).

On another note, HCPs acknowledged a lack of clarity in the role of specific discharge groups, whilst it was suggested that the hospital management needs to look after the entire resources. Moreover, fragmentation of hospital services was discussed by the physiotherapists and nurses. The role of specialist nurses was questioned by a nurse who claimed:

If discharge is done well then it will be all right ... but how many cases have you seen being followed by the discharge nurses? There are a million specialised nurses but how many discharge patients? If they're on discharge they have to be on every discharge. (FG1. Nurse).

However, another nurse asserted:

There could be a massive waste as well - we need to look at what manpower we have and we need someone to look after the entire service and try and join it up together and we have a lot of things. (FG1. Nurse).

6.6.4.2 HCPs' role in reassuring patient through information-giving

Nurses felt the need to reassure the patient by informing him/her early on about the hospital length of stay and the discharge process. Nurses also identified the need to set goals which encourages the patients, whilst emphasising patient diversity. Consequently, they expressed the importance of informing patients that their rehabilitation process starts immediately at the acute hospital and continues at the rehabilitation hospital only if required.

I think that we need to start earlier preparation for the discharge process, How is he going to discharge me so soon? Am I truly ready to go back in the community? (FG2. Nurse)

The physiotherapist agreed:

Even if we refer them to Karin Grech- there's a waiting list so we look after their therapy until they can go because there's room - but by then they're ok to go home; they would be under the assumption that they're going to Karin Grech. I think we need to explain better. (FG1. Physiotherapist)

The geriatrician acknowledged the lack of information-giving to patients. However, it was discussed that within the healthcare system there is always the aspect of uncertainty, even though information is provided continuously. He added:

In every case there's always an element of uncertainty, you can give information but you won't always be able to give decisive information all the time. Maybe, we don't explain enough even though he took a decision -

as in though he decided that this person is going to rehab, there was never any mention of when he was going (FG1. Geriatrician).

On the other hand, consistent information-giving by the geriatric team was confirmed by patients and their ICs and was perceived positively. The orthopaedic ward round was viewed to be brief when compared with that of the geriatrician's. A patient stated:

I found the geriatric's team to be very good here. Mr ... comes over but he doesn't stay long - he has to move on, but the geriatric doctors stay and talk, they give you the time, even half an hour sometimes (PT7).

6.6.4.3 Not knowing what to expect

This sub-theme explains that some patients were unaware of what to expect and all participants disclosed that, ideally, the information booklet should have been distributed earlier. Patients disclosed that they were afraid since they did not know what to expect and what is expected from them. A patient mentioned how he did not comply with the physiotherapist because of lack of information.

I did not want to comply with the physiotherapist because I was really scared. I remember that I was not afraid when I underwent the knee replacements, because the following day I had tried standing up, however I was really scared following this intervention. I thought that my bones would give way, because I did not know exactly what they did to me. I thought that my bones were weak and that they would give way if I tried mobilising. (PT4).

Various patients and their ICs talked about their worries which included: inability to regain their independence; coping once discharged; unaware about caring consultant and worried about transport to attend follow-up appointments. However, a patient acknowledged that the hectic ward and workload influences the time dedicated for communication.

Fear of the unknown and anxiety was discussed by a patient and his IC.

I worry that he's not going to come home even though he's not yet 70. I'm worried that he won't be independent enough. If they send him home for me, I'll help out as much as I can. (IC9. Wife).

Whilst the lack of information-giving by HCPs was discussed by most participants, a patient explained that although he was informed by his consultant he felt anxious, since it was his first experience in hospital. However, his IC suggested that information needs to be given beforehand, whilst another patient pointed out that HCPs should treat everyone as if they know nothing. A patient explained how his eagerness for independence had caused him additional stress. He stated:

I went to the bathroom alone and that is what scared me ... that I wouldn't be able to do it alone. I was terrified. Once, the nurse asked me if they had washed me ... I told her no; I do everything myself (PT3).

6.6.5 Theme 2: Participants' views on the information booklet

Whilst recognising the value of having an information booklet and that it: enhances communication; is a guide for the nurses and can reassure patients; the HCPs also mentioned certain issues namely; financial sustainability; limited literacy; cognitive ability and effective distribution. The participants offered some meaningful suggestions which could improve the effectiveness of the booklet. They mentioned adjustments to its presentation and making it more available to patients.

6.6.5.1 Perceived problems when using the information booklet

A concern discussed by HCPs was about finding the right time to distribute the information booklet. Some suggested distributing it on admission, but three nurse assistants and a physiotherapist argued that a patient in pain would not appreciate having to read the booklet. A nurse assistant explained:

If I go to present the booklet when the patient is still in a lot of pain, it would all be in vain and a waste of time. Once the patient is comfortably settled in bed, he will not have anything to do, so he will be interested to read the booklet and learn. I would give him the booklet after the patient has been administered pain killers and is comfortable in bed. (FG2. Nurse Assistant).

The HCPs agreed that the right time to hand out the booklet would be whilst doing the assessment on admission and they emphasized that a verbal explanation was also important. A nurse added that on admission it could help reduce anxiety.

Sometimes they have plenty of time to read the booklet because the operation is not performed straight away. I think that handing the booklets preoperatively will promote a reduction of anxiety because the patient will fully comprehend what to expect postoperatively. For example, they would know that after the intervention, they will be ambulated out of bed with the help of therapists. (FG2.Nurse).

Furthermore, nurses in both focus groups conveyed that handing the booklet at that stage is beneficial because, on admission, they are not given any documents as they are in the discharge process. A nurse assistant stressed that the booklet does not include only information on the operation but also information which may be useful during the patient journey. This was further supported by patients and their ICs (n=8) who suggested that the information booklet should be given on admission, or before surgery. They emphasized that if the booklet was handed earlier, it would have helped them to be more prepared for their journey and surgery.

And when they get admitted we're not giving them anything else - not like when they get discharged. I think they consider it more important than if we had to give them a booklet at discharge (FG1. Nurse).

I think it's better if they are given out before, because the fact that you know exactly what's going to happen is good. Even though ... knowing might not be such a good thing but the fact that it's there means you don't have to worry too much (PT6).

On another note, HCPs had mixed views about patient compliance with reading the information booklet. The majority of the HCPs believed that most of the patients and their ICs would read it. Furthermore, the OT had discussed two patient categories: there are those who ignore it completely whilst there are others who will take it very seriously. This requires HCPs to explain that the booklet is a guide and not written specifically for them, so they need to accept variation.

The physiotherapist explained:

There's always going to be a percentage of people who aren't going to read it (FG1. Physiotherapist).

The OT added:

There could be two problems which might arise when using the booklet. There will be patients who will ignore it, whilst others will get obsessed in the sense that they will end up thinking that every piece of information refers to their personal situation. It is then our turn to explain which piece of information is referring to that particular patient and which is the best option in their case (FG2. OT).

An additional difficulty viewed by HCPs was the costs of the booklet. A nurse argued that since health services are free in Malta, it should be free of charge. Whilst physiotherapists and nurses perceived that it would be worth the health department investing money for that kind of information, a physiotherapist added:

On the price thing my opinion is that if we as professionals think that this is a good idea we should say it. The person who sorts out finance it's his job to find the allocated funds for it which is evidence-based when you make the study. We spend so much money on useless things, sometimes, so why not on this (FG1. Physiotherapist).

To decrease expenses, some HCPs argued that it should not be printed in colour using a more standard paper. Participants also suggested the attainment of a sponsorship. However, this was not well accepted since the hospital cannot obtain sponsorships, especially from pharmaceutical companies because of ethical issues. Finally, another barrier anticipated by HCPs with the use of the information booklet was that with those patients who cannot read or with cognitive difficulties.

A problem which I foresee is that we have a lot of patients with dementia and we can't exclude them (FG1. Geriatrician).

Various suggestions were considered, for example, ICs or voluntary staff would read the booklet to patients with literacy problems. Also, two nurses suggested that it is the nurse's duty to inform the patient about their journey. Pictographs were also considered but it was debated within the group, since some nurses felt that it may be perceived by patients as something humiliating and childish for an older person. It was concluded that both can be used and patients would be handed an information

booklet according to their reading abilities. Media, such as video or audio recording on television or radio stations, was suggested by the geriatrician and nurses.

I do not know if the Volserv voluntary staff can maybe provide some input for the patients who cannot read. Ideally, responsible people should be appointed who are able to hand out leaflets and pass on information to the patients (FG2. OT).

A nurse shared:

These days there a lot of things in technology we could have tablets - it's easy to show them a video like that. Or a recording - a lot of older people like the radio so a recording won't bother them. (FG1. Nurse).

6.6.5.2 Perceived benefits when using the information booklet

HCPs identified that the information booklet is a good source of information to the older patient and their ICs. A nurse explained that if basic information is inadvertently missed, patients could obtain this information through the booklet:

And even if you forgot to mention something in particular, the patient can read it in the leaflet or book provided (FG2. Nurse).

A nurse continued:

The booklet even gives you information on what items you have to bring with you when admitted to hospital. There are cases when patients being admitted find difficulty in this regard and ask a lot of questions on the type of clothing that they need to bring with them. This booklet gives the required information since it takes into consideration such difficulties. For example, it explains why velcro slippers must be worn. We only know these things since we work here but the patients do not. (FG2. Nurse Assistant).

Nurses discussed that with the distribution of the booklet, patients cannot state that they were not informed and that verbal explanation is supported by written information.

Nevertheless, a nurse asserted:

We need to reassure the patients that what's happening to them is normal and they need to be prepared. For what they need to do - the book is great but it cannot replace personal contact and care (FG2. Nurse).

Providing patients with telephone numbers was considered as reassuring by HCPs, especially with those older patients who live alone. Besides, there was consensus that the booklet helps the patients and their ICs to understand how the hospital system functions. The geriatrician commented that the booklet is beneficial with providing further information on the process and on the MDT. HCPs also strongly felt that it avoids giving conflicting information.

And I think another factor is that you won't be giving a lot of conflicted advice ... it's hard in our area - one person tells you one thing and another says something else. This way, the patient doesn't get confused. (FG1. Nurse).

Further benefits were acknowledged by the nurses explaining that the booklet would help them to focus and will guide them, especially during discharge instructions. The OT commented that it is a point of reference for the patient, especially in circumstances which are beyond the patient's control.

I think that the booklet should be handed out on admission, because sometimes it is necessary to postpone interventions. Imagine I am the patient and I am lying in bed not having any idea what is going to happen to me day after day. The booklet will inform me that sometimes these things are inevitable but until I undergo the intervention, I know I can rely on the professionals who will take good care of me. I would know that one day, I will be given priority even though that day is still unknown. I think that they can use the booklet as a point of reference (FG2. OT).

Interestingly, the HCPs believed that the information booklet facilitates communication between the patient and HCPs. An OT illustrated how the booklet enhances communication.

I believe that since a patient listens to many different versions when visited by various members of staff such as nurses, doctors and physios. The patient will end up forgetting what s/he was told. But since it is written on the booklet, the patient can ... keep referring to it. Therefore, in the long run, communication will be improved (FG2. OT).

A nurse agreed:

I think it facilitates things because there are certain issues that got introduced by the booklet and the nurse and consultant go [into] more in detail with them. Both ways communication improves. (FG1.Nurse).

Additionally, patients and their ICs spoke about the benefits of the information booklet. Four patients stated that the booklet was a good source of information since it provided them with a better understanding about the type of surgery they had undergone, whilst helping them understand the consultants' explanations. Other patients stated that it had provided them with knowledge, helped them identify any complications, such as an abnormal increase in pain and helped them to better understand the situation. Besides, a patient explained that it is a reliable source of information which is always available.

Another patient argued that Maltese people tend to believe what other people tell them, rather than searching detailed information.

There are all the instructions here about what they did and didn't do. According to the book I know what happened to me. They told me they put screws so I referred to the book and I could see what they had done (PT10).

Also a patient clarified:

The booklet was a useful reference, however you need to experience the journey yourself to truly understand it. When you experience certain things, you will understand the concept. The doctor explained the procedure of hip surgery, however, I could not really comprehend. Now, I am starting to understand because I have experienced it and have read about it (PT1).

Three patients and their ICs mentioned that the booklet was beneficial because they can refer to it following discharge. One patient continued that it was reassuring because he and his wife referred to it and it eventually reduced their fears.

Like when there was the swelling ... The swelling there was, was in the ankle and its normal. It was fantastic because it really guided us until we settled. It kept our mind at ease (IC3.Wife).

I would have asked them, but the fact that there's the book; it told me what to expect and what to do. I think that they helped allay my fears - like my foot was [were] swollen and I [was] worried, but I read that it's normal after surgery (PT3).

Another two patients expressed that the booklet provided them with detailed information on all aspects of care and new in-depth information which was not explained before was provided in the booklet.

I realised that there were certain essential things which the healthcare team had not yet mentioned to me and it is thanks to this booklet that I was made aware of them. The information has made everything clearer since now I know what is going to happen and hence I am neither afraid nor worried anymore about the unknown. I am much calmer (PT5).

Patients (n=3) disclosed that the booklet had enhanced their communication with the MDT primarily by making them aware about the team members and secondly it guided them after being discharged from hospital. A patient clarified how the information booklet helped her to communicate with her relatives about the type of surgery. Conversely, a patient expressed that although the information booklet had helped to understand the roles of the MDT, he was disappointed to not meet his surgeon prior to being transferred to the rehabilitation hospital.

It helps to know the people who are helping you. It helps to know who's taking care of you - not you know no one (PT8).

When asked about whether the information booklet helped them to decide about their discharge, three participants explained that they left the decision-making process in the hands of the experienced professionals. Another patient further explained that the information available in the booklet assisted her to realise that she could become more independent and to be able to look forward to her return home. Also, an IC talked about his anxiety and how lost he felt on his mother's admission.

The rationale was because primarily he believed that a fractured femur leads to permanent disability and secondly he felt alone, since he was the only child.

The booklet definitely did one thing. Before, I used to think mistakenly, since I had studied 20 years ago that the broken hip is rather a permanent condemnation, which stays forever and which one could not recover from. And the booklet helped me realise that if this person puts her mind to it and does work for it, maybe she won't (recover) 100% but that she's able to go home, make her way to the restroom, showers and make herself a cup of coffee, yes, why not? Now, to tell you the truth, I'm gonna be honest, I felt just like a lost sheep during the first three days in hospital. I didn't [hadn't] realised what had just happened to me (IC6. Son).

Finally, another perceived benefit was that the booklet provides information on the hospital services. Three ICs and two patients also expressed that the provision of the telephone numbers was very useful, especially following their relative's discharge.

It's all helpful even if something happens you don't bother other people just find it in the booklet and call the number. I mean certain things like the hazards for sure and how to sleep and turn over and sit down and not to cross his legs (IC10. Daughter).

6.6.5.3 Ease of use and presentation of the information booklet

HCPs talked about the use and layout and all agreed that the pictures were useful in assisting them to better explain relevant information to the patient. Nurses commented that all the required information had been included whilst the OT commented that the booklet layout enhances readability.

The booklet is beneficial. The language used is easily understood and all the important information is found in here. The times, the services, everything is useful for the patient to know. This information will surely help our patient (FG2. Nurse).

The way this booklet is designed invites you to read it and not to ignore it. I think using this booklet will be a positive thing. Since the information is spread wisely into sections, it encourages you to keep on reading (FG2. OT).

The HCPs stated that the information was divided effectively into sections making it very user-friendly. The layout, including its size, colours, illustrations and font makes reading easier. HCPs also referred to the language used and added that it is easily understood by patients. All these aspects encourages the individual to read it even though it is quite long.

A nurse stated:

It has good use of colour and pictures. The information is divided wisely. It is enjoyable to read (FG1. Nurse).

Various other suggestions were received from the participants. An IC proposed that together there should be information focusing on fall prevention which should be distributed to all adults over the age of sixty. Half of the participants suggested that it should be divided into two, namely: one on preoperative care and another one on postoperative care until discharge.

Maybe to have two books, the bit before and one after because there's no point in giving it all to me after the operation. And what's going to happen when you go to Karin Grech that you need certain physio and what to do when you're in pain (IC8).

Another patient suggested that it should be divided into three short summaries explaining the three main types of surgery. Some concluded that there was nothing to be changed but presenting a summary would further encourage older adults reading the provided information.

A patient suggested:

Nothing! The booklet does not need to be changed or altered in any way however a smaller version of this would be equally important. (PT4).

When asked about the presentation of the booklet, patients and ICs had similar feedback as the HCPs. They revealed that the booklet was devised very well, easy to read, good use of sections and illustrations. Also, they talked that the language used was understandable in both languages without the use of jargon. All patients and their ICs who selected the Maltese copy were very satisfied with the language used even though the Maltese language is sometimes limited when it comes to medical terms. An IC commented that the font size selected had encouraged her to read it all.

It's very easy to understand - words we normally use - there's nothing bombastic and it's very self-explanatory. I don't find it too much to read

because the type is large – if it were smaller you'd skip bits. But what I'm saying is that if the writing was smaller you'd get put off (IC10. Daughter).

A patient and his wife described the booklet by saying:

I've never seen something that explains everything in so much detail and in simple Maltese. ... It's easy to read and not hard. And even if you do think that there's a lot to read there isn't - because the print is large and there are a lot of pictures and they skip a line. The pictures are well explained ... how to pick things up off of the floor, we have one of those things - how to avoid falling, look out for swelling. (PT9 and IC9 Wife).

Moreover, all stakeholders talked about the use of pictures whereby they believed that pictures would surely help the patients who are unable to read. HCPs in both groups had mixed views about dividing the booklet. Two nurses argued that the booklet should be divided by giving the patient only the discharge instructions, whilst another nurse pointed out that it should be divided into three small booklets. However, the other HCPs argued that if the information booklet were to be divided, it would not achieve its aim that is information-giving to patients.

I also agree that the booklet is given as a whole in one document, because we already agreed that the more information present, the more we reduce the patient's anxiety. If you divide the information in three separate booklets i.e. pre-operation, intra-operation and post-operation, one would not know what to expect exactly. (FG2. Nurse).

With regards to content, all participants were asked what information was viewed as surplus information in the booklet. However, all HCPs stressed that all information is necessary even though the booklet seems thick.

The physiotherapist explained:

At first I thought there might be but then I looked at it and couldn't find anything to remove. First you think it's a bit thick. (FG1. Physiotherapist).

The nurse assistant continued:

Then when you start reading it gets interesting (FG1. Nurse Assistant).

The majority of patients and ICs discussed that all information is useful and can be read at one's own pace. They agreed with HCPs that nothing should be deleted.

I think that what's good about it is that you don't have to read it all at once. Today, you can read the first bit and tomorrow another couple. I think it should stay as it is. If you have to read about more prevention you can read that too - it's enough. The material and sectioning is good (PT3).

I think it's all good and there's nothing extra. There's a lot of information and rules that we need to know about (PT8).

Interestingly, most patients and their ICs suggested adding more information rather than deleting any. They requested more information on the following: the exercise instructions; detailed information on the surgery; more elaboration on the HCPs' role and more knowledge on osteoporosis. Another patient preferred more information about fall prevention, on surgery, on the prosthesis and adverse reactions and what are the consequences if he sustains another fall, rather than on meal times.

I'm taking pills for it. If there was more info about it, that would be good. Maybe bone density for us too (male patient). I think elaboration on this would be good because at our age it's important. Some people haven't even done it (PT3).

An IC expressed that one of the disadvantages was that the booklet was too long for older patients and their attention might be lost. Two couples disagreed about its length and argued that all information is necessary and it includes the care pathway from admission until discharge. The patients also commented that information on pain relief was beneficial and that the booklet was a source of reference.

The sections are good. It starts from the operation and then moves on to what you can do at home. I don't think it's too long (PT3).

Not too long because when we had some difficulty we referred back to it and it went well. I think more information is better than less. At least if they're in pain they have some kind of reference I think there wasn't any extra information (IC3. Wife).

6.6.5.4 Suggestions for improvement on the information booklet

When asked to suggest any improvements to the booklet, a physiotherapist recommended that the caring consultants' name should be included.

Because we said the patient won't know the consultant ... can we have a box with sheets for operation ... name of patient etc. it used to be done ... like at school - my name is...? And I am under the care of Mr ... (FG1. Physiotherapist).

However, this suggestion was rejected by some HCPs because of data protection issues whilst others disagreed that this was a problem since patients keep the information booklet themselves. Similarly, two patients and their ICs recommended that the name of the caring consultant should be added.

An IC stated:

Maybe write down who the professor is. Or who would operate on you or take care of you. When I was operated on abroad they wrote down: You are under the care of Mr B. I had it all written down (IC3. Wife).

HCPs debated the general information on the hospital services and visiting hours. There was an agreement that meal times and visiting hours should not be deleted but further emphasis to educate people should be included. With regards to visiting hours, nurses stated that relatives need to respect other patients in the same room and hence, the importance of two visitors at a time should be explained.

You can have different case scenarios in the same room. Preoperative patients can be placed in the same room as postoperative ones who did their operation some days before. The patients who will be in the immediate postoperative period will experience pain. Thus many visitors next to one patient can hinder communication between the staff and the neighbouring patient due to excessive noise (FG2. Nurse).

Patients and their ICs agreed (n=4) with HCPs about informing the public to keep within the visiting hours because they argued patients need to rest. Also, they suggested that information about meal times was beneficial, especially for those who are unfamiliar with the hospital. Only a couple and a patient disagreed and suggested

that since a patient is in hospital there is no need for such information.

I don't think there was anything extra in the booklet - especially for people who have never been to the acute hospital. They need to know when meal times are and visiting hours and who they need to talk to and for what - and to get things explained. They'd be lost otherwise. So this booklet helps a lot (IC9. Wife).

In both focus groups HCPs acknowledged the involvement of the relatives proposing that they should be informed and handed an information booklet. The OT pointed out that this is particularly important with ICs taking care of patients with cognitive difficulties, such as dementia. Another nurse referred to her experience when she was assisting a relative who was abroad for orthopaedic surgery:

On admission, the nurse who came to do the assessment spoke to her and gave us the booklet and consent form. At that time I didn't really feel like reading the booklet but when she went into the op and I was left waiting I read it all and I was prepared as to what was happening. When she started feeling better a few days later I already had all the information and I knew what was going to happen. So even if you don't reach the patient - you have the relatives and they really appreciate it. For me, it was very useful and I got to prepare and I knew what I had to do (FG1. Nurse).

Furthermore, an educational campaign was suggested by the majority of HCPs to raise awareness about fall prevention, especially amongst older adults living in institutions and in public places. Also, organising talks or showing video clips to older adults on fall prevention were other recommendations to promote information-giving to older adults and their families. A nurse assistant explained that there should be a national campaign, similar to the anti-smoking campaign or drinking/driving. It was concluded that there should be no age limit for learning.

In this video you should include advice on what shoes to wear especially on carpets. I will inform the patients that the shoes they are wearing are not safe. Sometimes, you tell them that they need to change their shoes, but they answer that they find the pair of shoes comfortable, irrespective if they are unsafe. (FG2. Nurse Assistant).

Also a patient agreed with HCPs about more awareness since he believed that Maltese people tend to be unaware about fall prevention and health hazards.

I think that we Maltese people tend to be a little carefree. Let us take me as an example. I do not regard climbing on a ladder or stool that dangerous. I believe that we do not take care as much as we should. We do not take care of our health. I am talking about general health and safety (PT1).

Most patients and their ICs suggested educative television and radio programmes to inform older adults how to prevent falls and how to avoid them. An IC revealed that these educative adverts should be presented during peak hours. ICs and patients (n=6) recommended that a summary of the information booklet with pictures should be distributed in waiting areas, such as at outpatients, health centres and private clinics. A patient also stressed that information-giving should aim to reach those individuals who do not have any knowledge on fall prevention, whilst he recommended the health department to increase awareness through media.

I believe that we lack information to prevent falls in the elderly homes. The health department should set up video clips so that whilst people are waiting they can learn something beneficial, especially for these care homes. Some people tend not to take any notice, however even as simple as wearing flip-flops might contribute to falls. I think that implementing video talks would be a very good idea. A book can also pass on the message, however not everyone chooses to read it. Therefore, talks should be set up in which education is passed on to the elderly to make them aware on what to avoid (PT1).

Whilst IC2 explained:

Even on television because you'll take four slides and today people learn more by seeing than listening and whoever can't read or write it will be better (IC2. Husband).

Also IC4 added:

Promoting the short clips during peak time, like during a particular tele-serial, will help to reach more people (IC4. Wife).

6.6.5.5 Supporting information booklet with verbal information-giving

The importance of information-giving was agreed and emphasised between group members. All HCPs emphasised that their aim would not be reached if they just give the booklet without continuous verbal information-giving. There should be

continuous explanation on what is expected whilst they all agreed that there should be a team effort.

The book is very good and useful at giving a general idea. But there needs to be that person - the next day or the day after who explains to the patient what is going to happen to him and how it's going to go. (FG1. Nurse).

The majority of the patients recommended that the booklet should be supported by verbal information. An IC claimed that if the booklet is not supported with verbal information, then patients may not read it.

Probably a lot of people wouldn't read it because of that so it makes sense that you'll have someone explain a little (IC7. Wife).

6.6.6 Theme 3: Measures taken by patients / ICs after reading booklet

This theme depicts the actions taken by patients and their ICs after reading the information booklet. Precautions considered by both the patients and their ICs mainly focused on fall prevention and patients discussed their fear of falling again. It also presents information on whether and how the information booklet was read.

6.6.6.1 Increased awareness on fall prevention

Once again, this cohort of older fractured femur patients described extreme fear of sustaining another fall. They stressed that now they needed to be more cautious after this negative experience.

I'm scared I'm going to fall again - it's not the first time I've fallen mind you but this never happened before. It doesn't take much to just fall. I'm still afraid of falling. (PT5).

Some ICs encouraged the patients to be optimistic whilst advising them to be more careful. An IC explained:

You cannot stay thinking that you are going to fall. You need to always be careful. That way, you will not fall. You are aware and always careful not to fall. (IC4. Wife).

When asked about what they had learned or what action they decided to take after reading the information booklet, all participants focused mostly on fall prevention and health promotion issues. Interestingly, ICs also revealed that although they had not sustained any fractures themselves, they had decided to take precautions as well. Nine patients explained that they informed their relatives to remove all house carpets. Some of the ICs confirmed that they had already removed them, whilst others decided not to let their relatives mobilise, especially when cleaning the floor.

Yes, the first thing I did was remove all the carpets. And I took everything that was in the way, out of the way. And I took care after washing the floors - I turned on the dehumidifier and told him not to come in or get out of bed until the floor dried properly. Even though I broke nothing now I'm starting to take precautions ... I watch where I'm walking because before Christmas I fell. (IC3. Wife).

Other actions taken by the patient or IC after reading the booklet were to: avoid water spillage (n=6); use a night light (n=2); change to well-fitted shoes (n=2); not cross legs (n=2); use suitable chairs and beds (n=2); refrain from being over confident (n=2) and avoid climbing chairs or ladders (n=2).

I don't stand on chairs anymore to get things from high places - I don't quite know what to do though because I'm someone who's always up to something and I look after the house but now I'm not doing much. What's important to me is that now I heal as quickly as possible (PT3).

The ninety-three year old participant talked about taking three actions namely to: be careful how to walk, avoid water on the floor and if dizzy she did not mobilise but called for help. Two ICs explained how they became aware about the importance of regular eye sight and hearing tests to avoid falls and one of them commented:

Because I was going through the booklet and I can't remember exactly which of them it was but home assistance was one of them. Mind you, we did employ someone privately but home assistance was definitely one of them. This never occurred to me though: regarding the hearing and the sight check-up. It was something new for me. But first of all: she requires a regular eye check-up since it's already been two years from her last one. (IC6. Son).

Participants discussed that osteoporosis care is treated more in females than in males. Eight participants revealed that an important action is compliance with calcium supplementation in order to prevent osteoporotic bones. An IC stated:

The first thing that will happen at outpatients, upon visiting the specialist, is to understand what needs to be done with regards to bone density ... I'm not aware if it's too late or not (IC6. Son).

I was told that I have to start vitamin D and take it for life (PT4).

Further actions suggested by participants were health promotion actions, including healthy eating and exercise. A patient discussed the importance of exercise, whereas an IC argued that his mother used to buy and prepare food herself. IC6 commented:

And another lesson learnt ... My mum used to always take care of shopping so I know what she buys and she used to eat really healthy [healthily] ... But now, I'm being very attentive and I'm not trusting her (with shopping) anymore. So obviously, a long term diet is the basis of everything. (IC6. Son).

6.6.6.2 Patients' and their ICs' use of the information booklet

All patients and ICs stated that they had all read the information booklet and no one had any problems with reading it, except for one patient. This patient had been assisted by his wife since following surgery he had a slight eye irritation and had problems with his vision. Furthermore, all participants had read it sequentially starting from Section One until the end, except one patient and two ICs. All revealed that they did not read it all at once and others mentioned skimming through it again.

Yes I read it - what it is and how you can break your leg. I read more the bit to know how I broke it. Whether it was the hip or from underneath or the middle, so that I know how I am. I read [it] from beginning to end (PT2).

I only read it once because I didn't have the time. But I remember bits here and there. I read chapter by chapter (IC2. Husband).

Furthermore, when participants were asked whether they referred back to the information booklet following discharge, three patients commented that they

searched information on leg swelling as they were worried. Another five participants explained that, in future, they would definitely refer to the booklet, especially when they were in doubt or needed telephone numbers to clarify any concerns. Finally, another two patients explained that they do not refer to the booklet because they do not like reading the same information but they were keen to keep it as a reference.

I read the rehab part and she was a bit worried about the size and colour of her leg after and I had read it somewhere. Yes it was written (IC2. Husband).

Moreover, a patient suggested:

As I said before, maybe if it was given before - I can only talk in hindsight. At least I know how I need to get up and how to lie in bed and how to turn and not to turn. I think there should be someone to explain it beforehand (PT7).

6.7 Overview

The findings of this study highlighted that the information booklet was found to be useful by all stakeholders. All participants suggested that the booklet should be distributed to patients on admission, supported by verbal information-giving. Although some participants commented that the booklet may be too thick, they did not find any surplus information. It was suggested that the section on fall prevention in the information booklet should be used in educational campaigns to prevent falls amongst the older adult population.

6.8 Conclusion

This chapter presented the findings of this PAR Cycle and analysed the views of the stakeholders on the care pathway of older fractured femur patients. The patients and their ICs explained that their fall was a shocking experience which caused them psychological distress. Notwithstanding this, participants viewed their hospital experience as good and patients were satisfied with the care given. However, the results revealed that participants needed more information on their care pathway, specifically in relation to their surgery, rehabilitation and discharge. Moreover, participants identified facilitators that enhance the care pathway, such as good

communication and proper information-giving. All participants, including HCPs, acknowledged the need for more information-giving on the patient care pathway from admission until discharge.

The findings of Phase 3 of this PAR Cycle were also analysed. These incorporated stakeholders' views on the use of the information booklet developed to assist patients with their journey. This booklet was generally found to be beneficial by all participants and was viewed as a guide and source of reference following discharge. It was suggested that while it did not replace verbal explanation, it did enhance it. There was consensus that it should be distributed to patients on admission, preferably prior to surgery. Participants also emphasised the need for an educational campaign in Malta on fall prevention for older adults over 65.

These findings will be critically discussed in the following chapter within the context of the existing literature.

CHAPTER 7

DISCUSSION

7.1 Introduction

This chapter aims to discuss the findings of the PAR cycle which are interpreted and discussed in relation to existing literature, utilising the Habermas theoretical framework as a guide. In this chapter, the themes that emerged from the findings have been organised and discussed within the context of the research questions and objectives of the study. The findings include both similarities and variations in participants' views.

Since lack of information-giving during the fractured femur patients' journey was identified by stakeholders during interviews in the LOOK Phase, an information booklet was developed with the support of a group of participants. The findings of the stakeholders' views on the use and provision of the information booklet will also be discussed in the context of the existing literature. These findings suggest that some issues discussed by stakeholders are not specific or limited to the Maltese context but are also common to other countries, such as the need for information-giving, the importance of effective communication, inclusion in decision-making in the care pathway and the benefits of a well-planned discharge (Bull & Roberts, 2001; Olsson *et al.*, 2009; Bauer *et al.*, 2009).

7.2 Participant baseline data and demographic characteristics

This section discusses the findings of the three-month quantitative baseline data collection and the demographic characteristics of the sample participating in this study. This demographic data was important to give a clear picture of those who participated in the entire PAR cycle whilst presenting them within the Maltese context. This study showed that more females than males were admitted and that there was an overall increase in the age group of between 76 and 90 year olds. This is similar to findings in the literature and one of the reasons for this increase in

admissions of older fractured femur patients is due to the ageing population experienced in many countries around the world, a challenge which is causing a strain on healthcare systems (Teixeira *et al.*, 2009; Merten *et al.*, 2011; Hu *et al.*, 2012). Based on the literature, it could be argued that increasing age denotes increasing frailty, in that the 'oldest old' are often defined as being very frail with a high risk of functional limitations and multiple morbidities which in turn, increases the risk of falls at home and long-term care facilities causing dependency in self-care (Marks, 2010; Tchalla *et al.*, 2012; Jung, Shin & Kim, 2014). This notion is supported by the SIGN (2009) guidelines who noted that hip fractures occur mostly in frail older people with previous medical and dependency problems which denote the beginning of a complex journey. This would suggest that further investigations need to be conducted to establish fall prevention measures specifically for this age group, whilst adopting healthy measures to promote healthy bones.

Furthermore, the high incidence rate of fractures among female patients (64%) in this study when compared to that of males (36%) may be attributed to osteoporosis. This is supported by evidence whereby probabilities of osteoporosis were 23% higher in females than in males (Kanis *et al.*, 2012). The results also showed that although 82% of the admissions were from home, there was an unexpected amount of 12% who were admitted from an institution. Similar findings were reported in the literature which stated that older people living in an institution fall more often than those residing at home (Nurmi & Luthje, 2002; WHO, 2007a). Hence, this suggests the need for education on fall prevention in long-term care residents.

Exploring the hospital length of stay of this three month baseline quantitative data collected in 2013 revealed that more than half of the patients (51%) had a hospital stay of 1 to 10 days in the acute hospital. This average length of stay increased slightly when compared with the findings published in 2016 in Malta in a retrospective observational study resulting in an average length of stay of 11 days in the acute hospital (Cuschieri, Grech & Gatt, 2016). In England, the average length of stay in the post-acute stay was 4 days with an overall hospital length of stay of 19 days including rehabilitation (National Hip Fracture Database Annual Report U.K, 2015). Remarkably, the average hospital length of stay including rehabilitation in other European countries was that of 16 days in Finland, 13 days in Hungary, 17

days in Norway, 18 days in the Netherlands and 23 days in Italy (Medin *et al.*, 2015). Although the average length of stay in Malta seems less when compared with other European countries, local statistical data does not include the length of stay at the rehabilitation hospital which might have influenced the results. This signifies the need for further exploration on the patient length of stay at the rehabilitation hospital and for identifying the reasons why patients are staying longer in the acute hospital.

It was also evident that 56% of the patients in this study were discharged to the rehabilitation hospital which may imply that a rehabilitation programme helps patients regain their health to previous pre-fracture status (Kain, 2000) and prevents problems following discharge (Mistiaen *et al.*, 1999). The benefits of an orthogeriatric rehabilitation programme was studied in Malta by Zammit *et al.* (2016) who found a reduction in mortality rates for hip fracture patients when using the Nottingham Hip Fracture Score.

With regard to patients and their Informal Carers (ICs) the demographic data findings showed that more than half of the sample of the ICs (7 out of 12) were above the age of 70, meaning that older adults are being cared for by an older IC. It was clear that some of the ICs found it difficult to cope with their own ADLs let alone those of their frail relative. Such findings highlight the changing caring role of the Maltese family. This is similar to the findings of Troisi and Formosa (2006), Grima (2006) and Troisi (2013). They asserted that although the traditional Maltese family still exists, there is still a notable shift away from the traditional family. Their study showed that this is generally due to the increase in the participation of female family members joining the work force, thus reducing their availability to be informal caregivers. There is also the problem of increased longevity and as mentioned earlier, the inability of elderly relatives who are unable to take care of the more frail older family members (Troisi & Formosa, 2006). Consequently, this may indicate that the needs of the older fractured femur patient cannot be met by the family alone. They may need the support of rehabilitation programmes and community services which are supported by the state so as to decrease institutionalisation. Moreover, this may indicate a need for more studies in Malta on the socio-economic conditions of the family caregivers and a detailed analysis on the changing role of the family with reference to the needs and difficulties arising from

the changes which Maltese families and society are experiencing (Troisi & Formosa, 2006).

In the past, younger generations would generally look after their elderly family members. Today, more females are joining the workforce aiming towards broadening their career and educational achievements which have led to an increase in women leaving their unpaid traditional home environment towards a paid job. Also, families are becoming more geographically separated with daughters getting married and moving into newer housing, often in a different location and therefore are not so able to offer the same level of support as in the past even though distances on the island are not so great (Troisi, 2013). In this study it was noted that even sons were found to do their utmost to support their older parents during this difficult time. Therefore, one cannot deny the problem with the provision of daily care of older adults, especially with those who are frail.

When family members decide to assist their older fractured femur relative, the whole family goes through a time of reorganisation as they need to restructure their lives and that of their families (Troisi & Formosa, 2006). This may mean that children or an individual child becomes the primary caregiver of the older patient. This clearly highlights the need for support for patients and their ICs, especially when decisions need to be taken. This indicates that for decisions regarding the future care of the older fractured femur relative to be effective and relevant, the decision-making process should take into consideration the patients' and family needs and are not solely based upon what HCPs or policy makers think the needs of the family are. One possible solution would be the organisation of support groups for patients and their ICs. A representative of such a group could then assist the family to reach the most suitable decision to reach the best possible outcome for their relative, with the support of the HCPs.

Further findings showed that patients received immediate help by ICs at the time of an accident, since they frequently call their children rather than the emergency services. This was an unexpected finding. These findings provided evidence that although the family caring role is changing; family assistance is still given in times

of need. This was also evident upon patient discharge whereby children supported their older parents with self-care needs, help with domestic ADLs and the provision of respite care for the immediate post-discharge period. The presence of the family while an older patient is hospitalised may be very meaningful for the patient as the care and love provided by the family care givers makes a difference in the patients' lives, even if they are being cared for holistically. The presence of family members is crucial in the life of hospitalised older patients and helps them get through this difficult period in their lives.

Troisi (2013) recommends the need for further exploration on the social and cultural changes that have been influencing family support in Malta. It is worth noting that although the family caring role is changing, this study found that older patients are still being supported by their relatives. It is acceptable that most help still come from the family (Troisi & Formosa, 2006). Yet, this may suggest a need for a national study on the family structure and the changing family caring role. This study should also take into consideration the social, financial and psychological strains which influence the family supporting an older person under stress. The findings may help the policy makers to plan, according to the present needs of society, while taking into account the rapid change that the traditional Maltese family is undergoing.

This study sample included more female patients (n=11:5) in Phase 1 as well as in Phase 2 whereas in Phase 3, it contained more males (n=6:4). This gave an additional understanding on the fact that the eligibility criteria required that participants in Phase 3 had to be literate which might have influenced the sample. This was expected since around the Second World War poverty in Malta often prevented children from pursuing an education so that they could assist with agricultural work, which was a main source of income for many families.

Before 1946, school was not compulsory and parents' perception was often that girls were expected to help at home, thus preventing them from attending school. This was not so much the case with boys. In Malta, the illiteracy rate is clearly influenced by age and locality. In fact, in the more traditional localities the rate varies from 23% for older adults aged 90 years and over, to 10% for those aged between 60 and 70 (National Statistics Office [NSO], 2014). Over the years, the situation has changed

drastically and the same statistical information reveals a 94% literacy rate from the age of 10 and over (NSO, 2014). In addition to the above, one can easily identify that the majority of the HCPs were females. This highlights that despite the greater issues of professional characteristics in nursing, most still perceive it as a caring role (Watson & Lea, 1998) which was traditionally perceived as a career choice appropriate for females. Acknowledging the higher incidence of fractures amongst females, understanding the changing traditional caring role of the family in Malta, as well as having a better understanding of the participants' characteristics, provided a clear background of the setting surrounding this study.

7.3 Overall discussion of findings in relation to research objectives

This PAR cycle helped the stakeholders and researcher to identify issues of concern, to plan an action to the problem so as to then be able to implement and evaluate the effectiveness of the action taken (Stringer, 2014). Table 7.1 demonstrates an outline of the findings and how the research questions and objectives have been met from the findings that emerged in this PAR cycle.

Table 7.1 PAR Cycle findings: Research question, objectives and themes

PAR Cycle – Phase 1 and 3	
Research Question 1: What are the perceptions of the stakeholders on the current care pathway of the older patient with fractured femur from admission to discharge into the community?	
Study objectives: 1. To explore the stakeholders’ views of the current care pathway for the older patient with fractured femur from admission to discharge into the community.	
Themes (Patients and ICs)	Themes (HCPs)
<ul style="list-style-type: none"> • Perceived physical health prior to fracture. • Patients’ perceptions about the care pathway. 	<ul style="list-style-type: none"> • MDT approach as perceived by HCPs. • Patients’ care pathway as perceived by HCPs.
Research Question 2: How can the provision of care in hospital and subsequently in the community for the older adult with fractured femur be enhanced?	
Study objectives: 2. To identify facilitators enhancing the care of patients with fractured femur in hospital and in the community.	
Themes (Patients and ICs)	Themes (HCPs)
<ul style="list-style-type: none"> • Communication: Importance of information-giving. • Importance of preparation prior to discharge. 	<ul style="list-style-type: none"> • HCPs’ views on communication / information-giving. • HCPs’ views on discharge: Impact & challenges.
Research Question 3: How can patients, their ICs and the MDT be involved in the care of the patient with fractured femur in hospital and the community?	
Study objectives: 3. To analyse the readiness for change in the journey of the older patient with fractured femur in collaboration with the stakeholders. 4. To explore the views of the stakeholders on provision of information-giving to patients with fractured femur and their ICs from admission to discharge. 5. To evaluate the stakeholders impact on the information booklet developed for patients with fractured femur, their relatives and the MDT.	
Themes (Patients, ICs and HCPs)	
<ul style="list-style-type: none"> • Communication / information gaps in care pathway. • Participants’ views on use of information booklet. • Information booklet as perceived by patients and ICs. 	

7.4 The patient care pathway as perceived by stakeholders

In relation to the first objective of this study, **the patient care pathway as perceived by stakeholders** included four themes:

- Perceived physical health prior to the fracture;
- Patients' perceptions about the care pathway;
- Multidisciplinary approach as perceived by HCPs;
- Patients' care pathway as perceived by HCPs.

7.4.1 Perceived physical health prior to fracture

The findings showed that some patients were dependent on ICs and on mobility aids which shows that self-care prior to the fracture already involved someone/something else. In certain cases, older adults were being cared for by another aged individual. In fact, Triosi (2013) explained that the needs of frail older adults in Malta can no longer be met by the family alone without the need of specialised care due to various reasons namely; the changing role of women who, in the past, were the primary caregivers in Malta, increased longevity of the elderly where daughters/sons are already old themselves and the fact that families are now smaller also contributes to this. This suggests that patients need a robust rehabilitation programme including geriatric care so that they would be able to cope once discharged. This is beneficial according to the existing evidence which strongly suggests that the involvement of geriatric rehabilitation increases functional level, decreases institutionalisation and enhances the possibility for the patient to return to previous residence (Ellis *et al.*, 2011; Kristensen *et al.*, 2016; Stenquist *et al.*, 2016).

Findings from this study showed that just after the incident, patients' experienced psychological distress, feelings of loss of independence and anxiety about inability to cope. Some viewed their fall as a shocking experience, whilst all experienced tremendous pain. This is also consistent with the findings carried out by Archibald *et al.* (2003), Ziden, Wenestam and Hansson-Scherman (2008) and Gesar *et al.* (2017). Further findings revealed that the ICs' feelings were similar to those of the patients but they felt a responsibility towards the patients' health, acknowledged the patients' frailty and were anxious about coping. The responsibility to care for older parents

appeared to put pressure on the patients' children since it was evident that some found it more difficult to cope with the initial experience than others. Hence, the reported findings of patients' experience about the fear of depending on others, indicate the need for careful discharge planning whilst ensuring correct information-giving about the entire care pathway to patients and their ICs.

7.4.2 Patients' perceptions about the care pathway

This section discusses the patients' views on the hospital experience and the rehabilitation process. The lack of information at the emergency department was either because the patients were anxious and could not remember everything or that they had not been informed about such details. This suggests the importance of information-giving, obtaining patient feedback about their understanding whilst supporting information-giving with written information.

More than half of the sample were disappointed about the delay in timing of their surgery, which caused them unnecessarily long periods of starvation and feelings of discouragement. Conversely, results showed that those who were operated upon immediately felt encouraged and viewed it positively. The mixed results on the delay in timing for surgery sheds light on this issue which has been recognised as being the greatest challenge to hospitals in relation to the management of hip fractures since this influences length of stay, postoperative complications and the entire rehabilitation process. The pain and stress caused to frail older patients and their ICs because of the prolonged waiting times for surgery should be considered as well. This suggests the need for further local studies on whether such long periods of starvation are necessary.

This study also recognised the need for local guidelines on hip fracture management which guides HCPs and which eventually enhances patient care. Internationally, this issue is considered very important and various evidence-based guidelines on the management of hip fractures have been created, such as the SIGN (2009) and NICE (2011). A cut-off point period for delaying surgery was recommended to be between 24, 36 and 48 hours (NICE, 2011) whilst the NHS Institute for Innovation and Improvement in the U.K (2010) suggested a period of 24 hours from decision of fitness for surgery.

Obtaining perceptions from patients about the immediate postoperative period enriched the findings and contributed towards achieving a realistic view on the care pathway. Feelings of helplessness and discouragement due to complications were voiced by patients whilst some of the female patients felt empowered when socialising with other patients in their room. This illustrated that participants who were recovering from a fractured femur experienced pain, restrictions with self-caring and a decline in their physical health. Similarly, studies reported that hip fractured patients experienced greater deterioration in their quality of life and in their ADLs when compared with patients without a history of hip fracture (Hajbaghery & Abbasinia, 2013; Orive *et al.*, 2015). These findings are consistent with research studies which specified that this also contributed towards feelings of isolation, dissatisfaction and social isolation (Ziden, Hansson-Scherman & Wenestam, 2010; Kondo *et al.*, 2014). This suggests the need for developing supportive systems, both in the immediate and late post discharge periods. Through her work experience, the researcher has observed how older patients are often supported by other patients undergoing similar experiences. This occurs most frequently when patients with the same diagnosis are assigned the same hospital room, either on admission or when there is bed availability. This offers immediate support to the patients since cohorting fractured femur patients in the same hospital room are very likely to be encouraged by each other as a result of their shared experiences. In addition, to provide supportive systems in the post discharge phase, one might consider setting up a support group to encourage older patients to share coping strategies, to instil a feeling of belonging and to empower them to overcome any obstacles they are facing after the fracture. On a more social note, such groups could help patients and their ICs establish new networks and even possibly, expand their circle of friends. Another important role which could be assigned to these groups is the management of the information campaigns to inform the public on how to prevent falls, share experiences, establish networks and make new friends.

An important finding during the patients' interviews was spirituality which was defined in terms of religiosity by all stakeholders. Although it seemed that the majority of the patients on admission associated their fall with their religious beliefs, it was evident that patients referred to their religious needs more in the acute phase, rather than in the rehabilitation period. This lack of interest in meeting their spiritual

or religious needs in the rehabilitation phase could be related to limited mobility and fear of falling. However, the availability of religious services in hospital, such as daily Holy Communion helped patients meet their spiritual needs. Interestingly, ICs talked about spiritual needs as a coping strategy and some managed to continue with their usual participation in religious activities. This finding was similar to that highlighted by Azzopardi (2017) when exploring quality of life and spiritual coping strategies in older Maltese fractured femur patients and showed that they perceived themselves to be religious and others were also members of religious groups.

Obtaining perceptions from patients and ICs on their hospital stay showed a general feeling of satisfaction with care. However, various undesirable comments perceived by ICs were mainly about lack of psychological support, postponement of surgery, lack of information-giving, as well as discharge planning. One can immediately notice that the cause may be due to communication difficulties between HCPs and service users. ICs' undesirable comments about the acute and rehabilitation hospital were mainly about practices or rituals imposed by the hospital system; such as visiting hours, wrong timing of information-giving procedures and ward rituals. This shows that the hospital as a system might influence the patient lifeworld, as clearly explained by the Habermas (1987) Theory of System and Lifeworld ideologies. Moreover, the researchers' role in practice was to reflect on how communication problems or ward rituals are influencing the patients' hospital stay. Hence, a detailed study may help the ward to identify the barriers imposed on the patient by the hospital as a system. This may help the hospital to plan according to the patients' needs, whilst abiding with the hospital regulations and at the same time maximising patient safety.

Patients and ICs appeared to agree about the need for further rehabilitation since all participants felt that it is a form of continuity of care whilst patients viewed their rehabilitation hospital stay as very beneficial. This is consistent with the findings of an experimental research study by Shyu *et al.* (2010a) whereby geriatric input together with a well-planned rehabilitation programme was found to improve health outcomes in fractured femur patients. Also, participants seemed to agree about the benefits of geriatric care and the support they received following discharge. Similarly, research consistently shows that, besides other advantages, geriatric

involvement improved patient functionality, decreased institutionalisation and helped patients return home (Friedman *et al.*, 2008; Ellis *et al.*, 2011; Kristensen *et al.*, 2016; Stenquist *et al.*, 2016).

This study noted the lack of patient inclusion in decision-making in the care pathway which was disclosed by the majority of patients. However, some ICs and patients perceived that since HCPs were trained professionals, they were satisfied that their decisions were taken by competent experts. These findings also highlighted that other patients were satisfied that their discharge destination and rehabilitation programme had been determined by their children with the HCPs. Such findings may be due to the paternalistic attitude of HCPs in which decisions are taken based on what they think is best for the patient whereby the older patient is submissive with the decisions taken. Conversely, the notion that the doctor ‘knows best’ was clearly identified in this study by patients and ICs. A study conducted locally for the first time by Grima and Sammut (2010) confirmed these study findings whereby 95% had trusted their HCPs. On the other hand, the lowest statement scored (78%) was about the involvement of patients in decision-making about their discharge (Grima & Sammut, 2010). This suggests that culture plays an essential role in healthcare in Malta since older adults believe that HCPs are competent to take the right decisions. This cultural issue amongst the older Maltese patients where they believe that doctors know best and the decisions are to be taken by HCPs needs to be addressed. The researcher together with other HCPs could encourage patient participation by helping patients question about their own health especially during consultants ward rounds. It is important that patients know their rights and be self-care agents. This is similar to the patient charter statement that, each patient has “the right to participate in the collaborative process of decision making related to one’s particular healthcare needs” (Maltese Charter of Patient’s Rights and Responsibilities, 2016, p.12).

Further findings illustrated that non-medical decisions are sometimes taken by HCPs together with ICs. This study found that the aged couple completely entrusted their children with important decisions in their lives whilst some aged ICs explained that their own children met their informational needs, as well. Although this can be viewed as a paternalistic attitude, in this study the children’s involvement in decision-making was acknowledged by patients as something positive and

supportive of the entire family. Findings in this study also revealed that the involvement of ICs in the patient care pathway was perceived to empower the patients, enhance the rehabilitation process and prevent loneliness. These findings were supported by Lindhardt, Nyberg and Hallberg (2008) who found that when there was a low level of family involvement, patients reported low satisfaction. Moreover, this study's findings were confirmed by Dyrstad, Laugaland and Storm (2015) who found that family members were the older patients' advocates and supported them in the rehabilitation process.

A further finding in this study in relation to challenges encountered by patients in their care pathway was the pain experience. As expected, on admission the patients described their pain as a shocking experience. However, the majority were satisfied with pain management whilst hospitalised and they explained in detail how their pain had significantly decreased following surgery. These findings are similar with those of Griffiths *et al.* (2014) who found that although pain was discussed by participants it was not considered as a major problem especially following surgery. Although most patients claimed that they were experiencing minimal pain following discharge, this may be due to the fact that they were still on pain relief medication. Pain is very subjective, some patients might have a better pain threshold than others. A rationale for good pain relief management may be attributed to one of the advantages of the orthogeriatric care. This was reflected in the findings of Kristensen *et al.* (2016) who reported that patients in the orthogeriatric unit achieved better pain management when compared to the usual care.

An additional finding in this study was that few ICs explained that their relatives' pain remained unresolved which could be due to other comorbidities which were not related to the fracture, such as chronic osteoarthritis. Also, some participants mentioned that they were trying to reduce pain relief medications and seemed to be doing so without any instructions prior to discharge. This suggests further reflection on practice by HCPs on the information being given prior to discharge on pain relief. There is a need for more education in the clinical area amongst the staff on how the right information is given at the right time based on the patients' level of knowledge. It is important that when HCPs are educating the patients they ask for feedback in order to ensure that information given is understood. Hence, the researcher's role to

address the needs which have been highlighted is to organise ward-based continuing education about best patient education methods and about pain management so that HCPs can keep up to date with recent evidence.

It is an undeniable issue that caring for an older person after a hip fracture can be distressing for the main carer and the entire family. ICs participating in this study, irrespective of gender or affiliation with the patient repeatedly explained that caring for their relative was demanding, it was sometimes difficult to cope and had an impact on their family. It had influenced their physical health and social life whilst those married ICs expressed that the caring demands had an impact on their family. This finding was, in fact, emphasised across the literature exploring caregivers' experiences and reveal that family caregivers experienced burdens which had a negative impact on their health (Lin & Lu, 2005; Pereira & Botelho, 2011; Shyu *et al.*, 2012) In contrast, findings from Nahm *et al.* (2010) established that there is more to caring than just distress and burden, caregivers perceived the role as an opportunity to dedicate time to their loved ones. In this study, some of the male ICs were coping and viewed the experience as a learning one since they were learning how to take care of their spouse whilst managing the cooking and housekeeping. This reflects the need of careful planning prior to patient discharge in order to provide the patient and family with all possible information on available resources and on coping strategies.

ICs also discussed the financial impact of caring for an older patient with hip fracture. However, incurred financial costs were more in relation to buying specific medications and providing extra services which were deemed necessary by the ICs to assist patients in their ADLs, such as physiotherapy sessions. During the literature review, it was noted that most of the literature focused more on financial aspects with regard to hospital costs rather than the financial impact of caring on the family of the older fractured femur patient following discharge. This suggests further input on financial support that should be provided to encourage family members to continue caring for their loved ones at home. It is important that although the government is already supporting older adults over 75 years by giving financial incentives (€300 per year) (Budget Speech, 2012) to prevent institutionalisation, there should be an exploration on actual needs of the caregivers. In other countries,

various incentives to encourage potential carers included career payment, career allowance, government offers of specific allowances, respite stay per month and direct cash to paid carers (Dougherty & West, 2006).

7.4.3 Patients' care pathway as perceived by HCPs

Each member of the Multidisciplinary Team (MDT) participating in this study perceived that their role in the patient care pathway starts by a thorough assessment on admission. Results showed that each HCP viewed his/her role in the patient care pathway according to their specialisation. These findings also revealed that all HCPs gave priority to the physical aspect in the care pathway whilst when it comes to psychosocial and spiritual care, most of the HCPs had to be prompted. In fact, this finding was confirmed by patients and their ICs who requested more psychological input in the patient care pathway. Despite all this, it was evident that all HCPs on admission and in the immediate phase focused on the pre-fracture mobility status and very few HCPs discussed the patient available support in order to start planning the discharge. This highlights two important issues which indicate that the HCPs' role is more oriented towards the physical aspect in the care pathway, rather than viewing the patient holistically and the majority of the HCPs start discharge planning after surgery rather than on admission. This issue is considered in detail in Section 7.5.2.

The majority of the HCPs acknowledged the fact that they give more importance to physical care rather than to psychosocial and spiritual aspects. This is in line with the Habermas (1984) theory describing the conflicting issue between lifeworld and system. The fact that HCPs are more oriented towards the physical aspects of the patient care pathway may be due to busy environments, shortages of staff and because of the need to meet hospital demands and management expectations, such as, the pressure for beds (Wong *et al.*, 2011). This occurs when the care given and the communication style becomes procedural and ritual rather than communicative with older patients and their ICs. Therefore, there is a tendency that the hospital system may abandon the patient lifeworld by giving more importance to the physical aspects, rather than viewing the patient holistically. This issue was further reflected in comments by a nurse assistant who explained how the duty of care exceeds patients' need to spirituality. To conclude on a constructive finding it was revealed that all HCPs disclosed that when they identify any psychological or spiritual need they try

to address it to the best of their capabilities. It is noteworthy to highlight the importance of holistic care and the HCPs' emphasis should be on working with the patients' beliefs and values whilst involving patients in decision-making (Gesar *et al.*, 2017). This suggests the need for further reflection where HCPs examine their practice in relation to the older patient's psychological and spiritual needs.

According to this study's findings, all HCPs agreed that challenges existed when it comes to inclusion of patients and their ICs in decision-making. Literature consistently highlighted that inclusion and collaboration is the key to success in the patient care pathway (Young & Resnick, 2009; Digby & Bloomer, 2014; Rodakowski *et al.*, 2017). The importance of family involvement in patient care was studied in a SR of twenty RCTs who found that the involvement of family caregivers decreased the risk of rehospitalisation and lessened institutionalisations. In addition to the literature, this study's findings revealed that ICs, as with the HCPs expressed that as family caregivers they also need to involve themselves, so stakeholders considered it is a two-way collaborative process.

In this study, HCPs discussed two types of ICs - the overprotective and the active participants who decide for the patients. A disagreement amongst HCPs' views which included; those who believed that decisions were taken in advance by professionals, others perceived that patients are continuously involved and others disclosed that patients and their ICs decide for themselves especially when it comes to discharge. This was in accordance to the findings of Efraimsson *et al.* (2003) who found that older patient participation is questioned by the imbalance of power. Therefore, this supports the application of the Habermas (1984) theory in practice which helps to bring everyone in an equal position to participate in decision-making in the care pathway and discharge planning of the older fractured femur patient. Despite this disagreement, HCPs questioned the degree of how far patients are being informed in decision-making and recognised the need for further improvement. This would suggest that further investigation is required to establish the extent of participation that Maltese patients and their ICs take in the decision-making process in the patients' care pathway. Further studies should consider HCPs' level of participation in decision-making in the patient care pathway and whether patients' decisions are taken collectively as a team or by a particular profession.

In this study, the concerns that were raised by HCPs about factors influencing participation in decision-making in care pathway included; abrupt discharge decisions; hospital bed management system; ICs deciding on behalf of the patient; nature of the decision itself (decision about what type of surgery) and conflicting decisions between the patient and HCPs or disagreement amongst the patient and ICs. This is also consistent with research which reported that participation was influenced by time, work overload and the patients' condition, as well as patient preferences (Dyrstad, Laugaland & Storm, 2015) together with the pressure for beds and timely discharge (Donnelly *et al.*, 2013).

Another interesting finding was that HCPs, through their own experience, noticed that when patients attempt to be self-caring and is further encouraged by nurses they generally recover quicker. This is consistent to what is to be found in two SRs on the advantages of nurse-led care by Griffiths *et al.* (2009) and Crotty *et al.* (2010) who found it beneficial in decreasing readmission rates, decreasing institutionalisation and increasing functional condition.

This study's findings also revealed that all HCPs perceived that patients need physical assistance following discharge. It was determined that those who request long-term care did so due to cognitive problems; lack of social support; co-morbidities; frailty and mobility problems. Therefore, a need for further research was highlighted which would explore patients' needs and challenges following discharge and in particular, identify required needs due to frailty, utilisation of community services and social support.

7.4.4 MDT's approach as perceived by HCPs

Literature demonstrated benefits on health outcomes of the older fractured femur patient when a multidisciplinary approach is implemented in their care pathway (Stenvall *et al.*, 2007; Shyu *et al.*, 2010; Rostagno *et al.*, 2013; Hickman *et al.*, 2015). This study's findings showed several advantages of multidisciplinary teamwork through case conferences on the patient care pathway which are consistent with the findings of Griffith *et al.* (2004) and Efraimsson *et al.* (2006). This study made reference to MDT case conferences and it was determined that they enhance information-sharing about patient progress; help in discharge decision-making; bring

about a better understanding of patients' needs; improve teamwork; encourage decisions to be taken collectively; bring about better coordination and allow more time for planning the patient's rehabilitation. Although all were in agreement that the system of MDT case conferences was beneficial to the patient care pathway, there were inconsistencies in the responses when it came to decision-making and team collaboration with regard to the discharge decision. HCPs still believed that decisions were being taken by the medical hierarchy. This is similar to findings by Donnelly *et al.* (2013) who found that the care planning meetings incentive were more of a technical nature and an indication of organisational matters and communication was more of a procedural issue with the medical model taking over. This was supported in this study's findings when OTs disclosed that there is little collaboration, as they were made to feel like 'outsiders' by orthopaedic consultants.

Further findings revealed that nurses and physiotherapists discussed that although doctors consulted with them on the patient progress prior to decision-making, they do not participate in the weekly case conference. All participants, except one doctor, perceived that the absence of the medical profession in case conference meetings was causing problems with communication, discharge planning and time frames. Moreover, findings revealed inconsistencies between the doctors' answers, since the orthopaedic surgeon believed that the doctor's role is to decide on medical aspects rather than the discharge planning process. Again, this may be due to the power of medical dominance which takes over delegation of roles. This was in line with the findings by Donnelly *et al.* (2013) and was also discussed in the qualitative study by Bull and Roberts (2001). Also, in Efraimsson *et al.* (2006), findings revealed that case conferences were constrained by the institutional frame which indicates a type of rationality which Habermas (1984) refers to as 'system lifeworld.'

These findings support the view that it is imperative that case conference meetings are organised towards making older patients' voices heard and communication needs to be based and contextualised into what Habermas explains as 'lifeworld' (Habermas, 1984). Therefore, it is worth exploring whether the system of MDT case conferences in Malta is being conducted for the benefit of the patient or for the hospital system. As suggested by these findings, it is important that the hospital considers the patients' and ICs' involvement in case conferences. This is supported

by the Maltese Charter for Patient's Rights and Responsibilities (2016, p.12) which states that "one has the right to participate in the collaborative process of decision-making related to one's particular healthcare needs and to make an informed consent about one's treatment and care." The lack of involvement of patients and their ICs in case conferences may be because of the notion of power between the older patients and HCPs who are representing the health system. Additionally, the Maltese culture, especially with older adults, considers doctors more competent and qualified to make the decisions than their relatives. Another finding in this study was that HCPs viewed that holistic care is demonstrated more by the geriatricians when compared with the surgeons and orthogeriatricians spend more time with the patient during daily ward rounds. The benefits of geriatric care was consistently found to be beneficial in studies conducted by Ellis *et al.* (2011), Gregersen *et al.* (2012), Shyu *et al.* (2013), Lynch, Shaban and Massey (2015), and Kristensen *et al.* (2016).

This study showed that the majority of the HCPs felt the need for further improvement in enhancing collaboration between team members but the perceived needs were more oriented towards improving the team function rather than placing the older patient and their ICs as an equal member with the right to decide. The suggested improvements were oriented towards setting patient goals, enhancing communication amongst team members and including other professionals in the team. This implies that although HCPs' intentions were inclined towards the improvement of the case conference meetings, they still focused more on the efficient running of the ward. This study's findings is challenged by what Habermas (1984) believes 'communicative action' is, in that the acts of the participants concerned are organised not through 'egocentric calculations of success' but through actions of achieving understanding. Therefore, since HCPs believed in the need for better communication amongst the MDT, this may suggest staff activities including team building exercises. Furthermore, HCPs should be made aware about the benefits of involving the relatives in the entire patient journey.

Another important finding from this study was about case conference coordination as established by HCPs in that the nurse should be the one to update the team since nurses are well-informed, continuously with the patient and are a link between the doctor and patient, particularly during ward rounds. However, the role of each

member to update the team according to one's own professional role was not excluded. This suggests the need for nurses to reflect and explore whether their communication in view of the Habermas theory is influencing the patient care pathway. Nurses need to examine their own practices and assess whether their priorities are reflecting the hospital system and thus, their communication is based more on rituals rather than on the holistic needs of the older patients. In fact, it was consistently revealed in the literature that older patients viewed continuous, open and timely communication as fundamental in all stages for effective discharge planning (Bull & Roberts, 2001; Arora *et al.*, 2010; Kirsebom, Wadensten & Hedstrom, 2013). Moreover, when nurses were involved in the discharge process, patient and caregiver decision-making was promoted (Tomura *et al.*, 2011).

In this section, the findings were discussed in relation to the first objective of this study which was the exploration of the participants' perceptions on the current care pathway of the older patient with fractured femur.

7.5 Enhancing provision of care for patients' journey

The second objective of this research study was **to identify facilitators enhancing the care of patients with fractured femur, from hospital until their return into the community as perceived by participants**. It included four themes:

- Communication: Importance of information-giving;
- Importance of preparation prior to discharge;
- HCPs' views on communication/information-giving;
- HCPs' views on discharge: Impact and Challenges.

7.5.1 Communication: Importance of information-giving

Findings from this study revealed an overall patient satisfaction with communication and when requested to rate their satisfaction, the majority scored this highly. However, an important finding was that older patients felt that HCPs talk amongst themselves without giving enough feedback to the patient. Various factors were mentioned as influencing communication but the fact that patients did not want to disturb the HCPs is similar to what is found in the literature. In an action research

study, Atwal *et al.* (2008) found that communication was highly valued but older patients were very conscious of staff time restrictions that constantly hindered communication. In this study, the difficulties with communication may be because HCPs do not give importance to communication or they undervalue such needs. An additional rationale for the lack of communication and patient feedback may be due to the attitude of taking things for granted and believing that as professionals, we do not need to be told what the patient informational needs are. Hence, there is a need for continuous education to raise awareness about the importance of listening to patients, addressing their informational needs and empowering older adults to speak for their rights. Moreover, it is important to give older adults a voice to be part in their journey from admission until discharge. This is supported by Kirkpatrick (2003) who pointed out that the Habermas (1984) Theory of Communicative Action, supports older vulnerable patients when their voices are not considered. This research provided an opportunity for the older fractured femur patients and their ICs to express their opinions and participate in enhancing the care pathway from admission until discharge.

Further findings revealed the issue of time availability since older patients felt that they were not given sufficient time to communicate with their consultant. Conversely, the geriatricians' communication was found to be better and with less jargon. This supports the benefits of the involvement of geriatric care which is repeatedly studied by several researchers (Olsson *et al.*, 2009, Buurman *et al.*, 2010, Rotter *et al.*, 2010; Lynch, Shaban & Massey, 2015). In addition to this, sufficient time, good communication skills, nonverbal cues and frequent visits were concluded to be factors which facilitate patient communication. This is consistent with the literature which illustrates that to obtain the best possible patient outcome, care should consist of personalised and specialised care on the basis of effective communication (Olsson *et al.*, 2009).

Lack of communication between the hospital and the community doctor was found to be another issue following the patient's discharge. It resulted that most ICs informed their general practitioner regarding the patient's fall and condition. In addition to these findings, there was a small number of patients who felt confused because of inconsistent instructions between the discharging hospital and the family

doctor. This brought about conflicting advice received from the ward staff and the family doctor and the patients could not decide which advice to follow. The involvement of the general practitioner may be either, since information given by the discharging hospital was not clearly explained and not documented on the discharge summary or because it lacked clarity. This, therefore, suggests that the nurse responsible for discharging the particular patient should possibly simplify the way information is given, then ask for feedback to ensure that the patient has understood everything and failing that, repeat the information given. This was reflected in the findings of Allen *et al.* (2013) and Johnson, Sanford & Tyndall (2008) who demonstrated the need for better communication between hospital and community and for more detailed information to be given to the patient to assist in effective management at home. Consequently, this validated the need for an effective information booklet to further enhance patient knowledge and ease patient transition.

The majority of the respondents indicated that they felt at a loss and were confused throughout their care pathway. Despite the fact that the patients and their ICs had been informed about the need for surgery, they still felt the need for more information on the following: type of surgery and anaesthesia; advantages and risks of surgery; hospital length of stay; recognition of complications; rehabilitation process; discharge and coping strategies.

This study's findings showed that the patients' and their ICs' main concern was lack of information. In turn, this caused the patients to experience stress, confusion and continuous doubts about their walking abilities. Such findings are consistent with Olsson *et al.* (2007) who found that although all patients perceived their rehabilitation positively, all required more information and all subjects were worried about their ability to walk again even though they had all regarded life enthusiastically. This finding seems to suggest that insufficient information causes unnecessary stress, which eventually appears to influence the rehabilitation process and might have an impact on the abilities of the ICs to cope with the situation. As already discussed in the findings chapter, the lack of information may be very discouraging for the older fractured femur patient, as can be noted in the following excerpt from a patient.

I am not satisfied with the information I was given. I was only aware that I had to take the treatment I was given and that's all. I was not given the chance to ask anything at all. They did not tell me about the fracture itself and the following treatment. All they told me was that I would have to go for therapy and that's all. (PF1, Jane).

An interesting finding was that although pain was not considered as a major concern for patients following surgery, informational needs on pain management were discussed by participants following discharge. The majority of the ICs stated that they were unable to help their relatives with pain management due to lack of information. Feelings of frustration and anxiety were shared by an IC when a patient was unable to walk due to pain. Also, findings showed that patients were unaware about the pain relief medication they were taking. Literature on this issue illustrates that the lack of information on the management of medication was found to be the commonest problem after discharge (Arora *et al.*, 2010; Waring, Bishop & Marshall, 2016) causing unwanted incidents and patient dissatisfaction (Mesteig *et al.*, 2010; Knight *et al.*, 2011). Hence, it is suggested that a pharmacist and/or nurse should create a form containing clear information and instruction about the treatment to be continued at home, preferably with pictures. This should be given to patients and ICs prior to discharge. This may enhance compliance with medications, decrease drug medication errors and increase patients' and ICs' knowledge about the treatment. Providing written information was consistently proven to be beneficial to patients. New, McDougall and Scroggie (2016) found a significant improvement in patients' knowledge after a hospital sheet was given to older patients.

An additional finding which caused unnecessary anxiety to the patients and their ICs was the issue of follow-up visits. Findings revealed that some had problems with follow-up appointment times and others had never received any follow-up appointment. ICs revealed that because of incomplete information, they felt frustrated and had lost their trust in the healthcare system. However, these problems are once again unnecessarily created due to the lack of correct information-giving. Consultants do not usually request any follow-up appointments except for those patients who have sustained complicated fractures. Since the staff does not sort out such misunderstandings, patients and their ICs remain anxious about their follow-up appointment. One might argue that what seems to be ritual and usual for HCPs,

might seem to be an additional concern for the patient. Yet again, this supports the need of giving patients and their ICs written information. This was found to enhance participation in care when patients are discharged (Johnson, Sanford & Tyndall, 2008; Bench, Day & Griffiths, 2011; Tomura *et al.*, 2011; Weiss, Yakusheva & Bobay, 2011).

In addition to these findings, all patients who continued their recovery at the rehabilitation hospital criticised the transfer process, as it had happened haphazardly. This finding was supported by the ICs' results who showed their dissatisfaction about how the transfer had occurred. This may be due to the following reasons: when there is a shortage of available beds; transferring of a patient could happen too quickly and without proper preparation and also, although patients are informed about being on a transfer waiting list, they are not clearly notified on the details of how the transferring system operates. Both hospital systems have an agreement that the next patient on the waiting list at the acute hospital will only be called once a bed at the rehabilitation hospital is vacated. This might cause this haphazard transfer. Likewise, HCPs are only informed about the transfer when they receive a call from the rehabilitation hospital about a particular patient and requesting immediate transfer. This is explained by the Theory of Communicative Action where Habermas (1984) distinguished between instrumental, strategic and communicative action (Section 3.2.2). HCPs adhere to technical rules by adopting an instrumental action, which is imposed on them by the system that operates on pressure for beds and timely discharges. A communicative action influences HCPs to strictly abide to protocol. Another factor contributing to this lack of information is due to the lack of awareness about patients' and ICs' perceived informational needs.

In contrast to the above findings on information-giving, a small number of patients and their ICs felt satisfied with the explanations about the patient care pathway. Some patients and their ICs felt encouraged and empowered when informed about patient progress, whilst all patients valued the physiotherapists' and occupational therapists' teaching sessions. This supports the argument that when patients and their ICs are given timely and sufficient information, they will experience less anxiety and uncertainty, whilst giving the patients more power over their own situation.

Therefore, according to the Habermas (1984) Theory of ‘System and Lifeworld,’ having an informed patient signifies that the patient’s lifeworld functions in association with the hospital as a whole system. Research reveals that anxiety and uncertainty may be alleviated by empowering the patients to feel more confident, if more information is given (Boughton & Halliday, 2009; Murphy & Reddy, 2017).

Despite all the challenges encountered in the patient care pathway, the patients and ICs acknowledged the ward workload whilst they pointed out that it is also their responsibility to seek information. Another finding was that most patients and ICs emphasised the need for written information. Other studies also recommend the need for written information as a valuable source of patient education (Demir, Ozsaker & Ilce, 2008; Gustafsson *et al.*, 2010) and this is found to be essential since patients admitted as an emergency, scored lower for quality of information-giving than those with scheduled admissions (Frojd *et al.*, 2011).

7.5.2 Importance of preparation prior to discharge

The importance and benefits of proper discharge planning have been widely recognised over the years, yet barriers leading to poor discharge planning remain constantly evident in research findings around the world (Naylor & Keating, 2008; Nosbusch, Weiss & Bobay, 2011; Weiss, Yakusheva & Bobay, 2011; Wong *et al.*, 2011; Okoniewska *et al.*, 2015). In this study, the majority of the respondents indicated several factors which had influenced their discharge process. These were mainly related to organisational problems, lack of communication and insufficient information-giving. Factors hindering the proper discharge process included: no estimated discharge date or transfer to the rehabilitation hospital; change in discharge destination; lack of information; lack of planning; ward workload and communication problems. This was in conformity with the findings of Watts and Gardner (2005); Day, McCarthy and Coffey (2009) and Rose and Haugen (2010).

Results also revealed that unexpected discharges, often decided on the same day, prolonged waiting time for the discharge summary and inconsistencies in the discharge process were the primary reasons for confusing, stressing and frustrating patients and their ICs. This had caused both physical and psychological unpreparedness for such a transition. All this may be due to: a lack of proper

discharge planning; no formal discharge planning interventions; discharge planning delays as planning was not started on admission and that the patient has to wait for the review as discharge is decided by the medical profession.

Various studies in systematic reviews illustrate that discharge planning interventions are found to be beneficial for the older patient (Parker *et al.*, 2002; Fox *et al.*, 2013; Goncalves-Bradley *et al.*, 2016). Over and above this, as discussed in Section 7.4.2, there is also a lack of patient involvement in decision-making. As guided by Habermas (1984) in the TCA on explaining strategic action, one questions whether the ‘culprit’ behind these findings is doctors’ attitude of ‘knowing best’ or else as Godin *et al.* (2007) explained, due to HCPs taking control of the conversation with the use of jargon to overwhelm patients and hence, arrive at the HCPs’ preferred end points. The medical model dominance was evidently demonstrated with this study’s finding, which found that consultants could discharge patients on the same day, without proper discharge planning. There is still this cultural issue amongst older Maltese patients, where they believe that decisions are to be taken solely by the doctor and they, as the patients, need to abide by them. It would be interesting to explore the influence that culture has upon the decision-making process in the patient care pathway in Malta and whether this issue is related specifically to older adults.

Factors encompassing the above findings were therefore: lack of communication, information-giving and involvement in decision-making. This left patients and their ICs with no options or time to think about their discharge destination. Literature on this issue illustrates that this may be due to the fact that HCPs are more concerned with addressing biomedical issues (Rockwell, 2010) and HCPs’ standpoints are frequently guided by patient safety (Durocher & Gibson, 2010) rather than a holistic view. Hence, one cannot consider the discharge planning process separately or simply focus on solving a problem without thinking it through a patient-centred approach. This study shows that it is essential to involve patients and their ICs in the discharge planning process. In fact, research consistently supports the involvement of patients and care providers from admission until discharge and beyond (Archie & Boren, 2009; Foss & Askautrud, 2010; Augustinsson & Petersson, 2015; Rodakowski *et al.*, 2017).

Conversely, factors perceived by the participants of this study to enhance the discharge process were: family support; patient education; patient's physical condition and functional status; multidisciplinary approach; educational sessions on self-caring; awareness on patients' needs; good nurse-patient and IC relationship and good discharge planning. These are similar to the findings reported in the literature by Zakzesky *et al.* (2015) and Chaboyer *et al.* (2016). However, most respondents consistently emphasised that family support was the main factor that enhanced their discharge process. This was substantiated by another finding which showed that ICs went out of their way to prepare for all the patients' needs prior to discharge, with some of them even paying a substantial amount of money out of their own pocket. Further findings highlighted the positive remarks made by both the patients and their ICs about the valuable preparation by the OTs regarding home adaptations prior to discharge. An additional outcome was that children supported their parents in the immediate discharge period by making adaptations at their own homes and providing a period of respite care until the older parent fully recovers. This, and frequent visits from friends and support groups, was found to be encouraging for patients. This finding is confirmed by Troisi (2013) who reported that an imperative part of care of the older patient is still provided by family caregivers in the informal sector.

Most patients highlighted their biopsychosocial needs following discharge. As expected, these needs were mainly related to self-care, especially with mobility, whilst ICs were satisfied with their relatives' unexpected successful recovery. Although patients' success was characterised by support given by ICs to reach self-goals, one might point out that personal traits and courage might have influenced the recovery process. People react in different ways to one another, even when faced with similar situations since each person is unique in his/her own ways. This finding suggests the need for further studies to investigate the effect of patients' personal characteristics on the rehabilitation process of the older fractured femur patient.

The older patients' experiences about the recovery process highlighted in this study, were found to be similar to other international studies revealing that patients experienced psychosocial problems due to life changes after experiencing a fractured femur (Olsson *et al.*, 2007; Zaiden, Wanstead & Hansson-Sherman, 2008; Zaiden, Hansson-Sherman & Wanstead, 2010; Kondo *et al.*, 2014). This is consistent with

such finding, as it was revealed that Maltese fractured femur patients went through a period of psychological distress, discouragement, guilty feelings, helplessness and dependency on others. Despite the support patients received from their family members during their hospital journey and following discharge, all patients and ICs agreed that there is need for psychological support. At this point, the researcher's role is to raise awareness with the hospital management and the multidisciplinary team about the need for psychological support in the patient care pathway. Moreover, it is imperative that the findings of this study are communicated with all stakeholders so that actions to improve the care pathway of a patient with fractured femur are grounded on evidence.

In another study conducted recently in Malta in older fractured femur patients, it was found that the poorest quality of life was felt to be in the physical and psychological domains (Azzopardi, 2017). These findings also illustrate that ICs were aware of the reasons for the patients' psychological distress. ICs also experienced their own psychological difficulties and they mentioned experiencing loneliness, anxiety and tiredness, as well as feeling guilty and being afraid of the unknown in relation to the new caring roles. It is therefore worth discussing the need to explore the involvement of a psychologist in the patient care pathway with the multidisciplinary team and hospital management. Psychological support was also suggested by ICs, which would assist them with coping strategies following discharge. In summary, although ICs experienced initial shock and the new responsibilities may have caused them some instability in their normal lives, they all expressed that they were coping. It was reported that the patients' and ICs' social life suffered as a result of the fracture, which was reported to be due to limited mobility and fear of falling again.

With regard to continuity of care in the community, most patients and ICs were unaware of what was available by way of community services, they did not know how to apply for them and they had no knowledge of the costs involved. ICs believed that it is the HCP's role to inform the patients prior to discharge about such community services. Conversely, as explained by the ICs, the necessary information might have been given to the patient who may have forgotten what had been said. This lack of information on community services could also be due to the fact that the

patient had refused such help. One might question whether HCPs are actually aware about the available community resources.

This study has highlighted that preparing the patient for discharge is usually quite hectic due to the quick transfer time. It is likely that if they had more time, the HCPs would be in a position to inform the patients about such services more effectively. This lack of information regarding community services was discussed by participants who suggested the importance of producing written information. The fact that ICs demonstrated the need to know more about existing community services might imply that family members are still interested in taking care of their older parents. Since this study focused on the patient care pathway from admission until discharge into the community, it would have been interesting to explore whether the use of community services in this group of patients would have enhanced patient independency and thus prevented institutionalisation. This was however deemed to be beyond the aim of this particular study. In fact, findings showed that there is a need for an increase in community resources which are desired specifically for fractured femur patients, such as an increase in the hours of home help and the need for a community physiotherapist and social worker. This finding is similar to those of Connolly *et al.*, (2010) who reported that HCPs strongly agreed that discharge could be enhanced by the improvement in community services.

When participants were asked to define the term ‘intermediate care’ very few were familiar with it. However, following a brief explanation, most participants perceived it as advantageous since it enhances communication, provides support, promotes continuity of care and teamwork, decreases stress of transferring between hospitals, is beneficial for hospitals and that care is provided at home. The benefits of intermediate care are supported by studies from different countries including staff job satisfaction (Nancarrow, 2007), support in favour of discharge (Martin *et al.*, 2007; Dahl *et al.*, 2014) and how to avoid readmissions (Murphy & Logan, 2009).

7.5.3 HCPs’ views on communication / information-giving

Further findings show that all HCPs inform the older patients about their care pathway only in relation to their professional role. For example, the OT informs patients on self-care and adaptations. This study highlighted that it is generally the

nurses who inform the patients about the need for surgery, the importance for physiotherapy, the rehabilitation process, the possibility of transfer to the rehabilitation hospital and finally what to expect once they are transferred. This may be since nurses spend more time with the patients and are therefore in a better position to communicate with them. They can also easily assess patients' informational needs and patients are more likely to engage in discussions with them and sort out any queries. It was suggested by Maloney and Weiss (2008) that if the patients' informational needs are met prior to discharge, this establishes the way forward for successful management of care and recovery at home.

When discussing factors which influence communication and information-giving, the HCPs reported more hindering factors than the patients did. In addition to the findings regarding patients' views (Section 7.4.2); HCPs reported hearing problems, language and speech difficulties, pain, noisy environment, medical jargon and problems with cognition. Other interesting hindering factors were the hospital on call system, patient attitudes, other HCPs' judgemental attitude, unclear instructions and the ICs' inability to meet HCPs. Furthermore, through the researcher's own experience which is supported in the literature, there are: the hospital environment; the degree of patient turnover; the factor of not knowing what to expect and what is expected; health policies and HCPs' role may all further reinforce hindering of effective communication (Atwal *et al.*, 2002a; Watts & Gardner, 2005; Rose & Haugen, 2010; Toscan *et al.*, 2013). This finding suggests the need for further studies on patients' hospital experiences, in order to offer greater insight into their fears and to examine the communication processes between patients, ICs and HCPs.

The literature on this issue is clear. If HCPs need older patients to comply, their role is to explain; what is happening, the rationale for actions, what is expected from them and what the norms are within the entire recovery process. As outlined by the Habermas (1984) TCA, these should be done without the use of jargon, by asking for feedback whenever possible and by considering patients as equal collaborators, where all participants are equal in the decision-making related to their care. This argument was substantiated by the HCPs' findings in this study since they commented that family involvement, nurse-patient relationship, encouragement, honesty and information-giving were the most important factors which enhance

communication. These findings were similar to those found in literature on HCPs' perspective about communication and which highlight four main communication themes, namely: 'mutuality and information-giving,' 'patient-centred care,' 'inclusiveness' and 'clear outcomes' (Donnelly *et al.*, 2013).

HCPs stressed the importance of the multidisciplinary approach in the patient care pathway, they mainly share information on the physical aspects and shared within the team very frequently and according to the patients' needs. Findings showed that Maltese HCPs regarded information-sharing as a team effort and valued all members as equally important. Research consistently found that when the MDT approach was implemented in the care pathway of the hip fracture patient, it resulted in benefits on health outcomes (Stenvall *et al.*, 2007; Shyu *et al.*, 2010b; Rostagno *et al.*, 2013; Hickman *et al.*, 2015). An ethical dilemma on whether confidential issues should be shared amongst the MDT arose between HCPs. Habermas (1984) explains that getting everyone to accept a valid claim incorporates the notion of argumentation. However, after presenting their own arguments, all HCPs involved in this study agreed that if the information that needs to be shared is for the patient's well-being or is in order to prevent any harm to others, then it would definitely merit the disclosure of information. Furthermore, it would be interesting to organise ward-based activities on how to nurture teamwork and understand team dynamics.

Findings also showed that the creation of virtual groups was found to be a good source of information-sharing amongst colleagues. These could be taken as a source of educational opportunity for HCPs. It is important to conduct further studies in clinical practice on how to include patients and their ICs so as to optimise information-sharing, which eventually enhances patient care.

7.5.4 HCPs' views on discharge: Impact and challenges

Most HCPs emphasized the importance of continuity of care and they explained their methods for handing over patient information. To ensure this important factor, nurses explained that when transferring a patient, information is passed on both through written and verbal communication. As with the patients, HCPs found that preparing for quick patient transfers, having unclear discharge plans, as well as lack of time and poor communication hindered efficient patient handover and transfer.

A dissimilarity about continuity of care exists between the patients' views and doctors' findings. Doctors commented that when a patient needs to be followed by the GP, a verbal explanation is given to the patient and the information is documented on the discharge summary. However, patients claimed that they were not informed about any such things regarding continuity of care. Similarly, physiotherapists and OTs explained that a follow-up appointment is scheduled depending upon patients' needs and progress but the patients often mentioned how anxious they felt about not receiving any follow-up appointments from either the orthopaedic or physiotherapy departments. All these inconsistencies may be due to the fact that on discharge, older patients may have become confused by the unplanned discharge or transfer and were therefore unable to absorb and comprehend all the information that was said to them prior to this. Therefore, this suggests the need for the trauma orthopaedic ward to have a standard discharge planning protocol which incorporates the rights and responsibilities of all stakeholders. Moreover, an action research design which allows change to occur in practice should be conducted with all stakeholders, to develop structured discharge plans according to the patient's discharge destination. These suggestions should provide HCPs with instructions and bring about the standardisation of the discharge process whilst preventing inconsistencies in advice. The importance of an agreed comprehensive discharge plan depending on patients' needs was highlighted in different studies (Bowles *et al.*, 2008; Lin *et al.*, 2009; Tomura *et al.*, 2011). A significant difference was found in patient knowledge when a discharge plan was utilised (Lin *et al.*, 2009).

Results showed that participants agreed that the discharge process was a stressful event for the patient and that it was perceived as doctor-led even by doctors participating in this study. Hence, the need for free open communication which is unrestrained by the burden of power is key to participatory democracy (Habermas, 1984). It is suggested that there is need for open communication between the multidisciplinary team and the patients, so that decisions can be taken as a group and not by an individual professional. The findings of this study clearly show that delays in initiating the discharge planning process were partly due to the lack of an expected discharge date which, in itself, causes a lot of problems. Starting discharge planning from admission is frequently suggested in the literature by defining it as a process that aims to include safe transfer even, when possible, prior to admission to hospital

and back home (Goodman, 2010; Nosbusch, Weiss & Bobay, 2011; Brent and Coffey, 2013; Nordmark, Zingmark & Lindberg, 2015; Zakzesky *et al.*, 2015).

Perceived inadequacies in the current discharge process were lack of information, late transfers and no discharge guidelines. Other factors hindering the process were organisational and patient-related factors. Findings exhibited that nurses, as with patients, feel that the discharge process is a stressful event in their daily practice, because they often need to discharge the patient without much warning. This was further emphasized by the other members of the MDT who explained that the lack of communication, delayed involvement and the unexpected discharge, all hindered the entire discharge process. These findings are consistent with the findings of Wong *et al.* (2011), Okoniewska *et al.* (2015) and Chaboyer *et al.* (2016).

Studies on HCPs' views on discharge planning mainly focus on the actual process and the impact it has on the patient (Nosbusch, Weiss & Bobay, 2011; Sims-Gould *et al.*, 2015; Waring, Bishop & Marshall, 2016). This is exactly in line with what was found in this study, where HCPs mainly focused on the medical condition of the patient, the need for information-giving on self-care, compliance with medication, coping, ability to mobilise safely, as well as prevention of further falls. An important finding was that all HCPs acknowledged the need for improvement in information-giving prior to discharge in relation to their profession. For instance, a doctor stressed that although she informs the patient on physical aspects, she feels it is necessary to reassure the patient prior to transfer to the rehabilitation hospital. This suggests the need for more patient-centred care and holistic assessments to evaluate the patients' needs, as well as to organise the required support for successful discharge (Cotera-Perez-Perez, 2005; Johnson, Sanford & Tyndall 2008; Wong *et al.*, 2011; Pellett, 2016). Obtaining perceptions from HCPs enriched the findings which contributed towards the decrease in the gap between research and practice.

HCPs acknowledged the need for the development of an information booklet, which could be a source of reference once the patient is discharged and help improve the discharge process. HCPs recommended that the booklet should include: information on the fracture; expected care pathway; outcomes; information on team members; possible discharge destinations and what the rehabilitation process involves. This

was supported by literature which explained the various possible methods of presenting information such as, dissemination of information sheets, information booklets and manuals, visual representations, interaction websites and telephone helplines (Mistiaen & Poot, 2008; Choi, 2011; Schmidt, 2013; Langford *et al.*, 2015; Tsui *et al.*, 2015; New, McDougall & Scroggie, 2016). These findings enhanced the development of the information booklet since it was developed on the stakeholders' suggestions. It was proposed that written educational material should be developed by health professionals according to guidebooks and by including the target group (Demir, Ozsaker & Ilce, 2008; Tsui *et al.*, 2015). These findings also support the need for further larger scale studies about how the discharge process is being conducted in practice and how this can be improved. It is suggested that the hospital should engage in evaluation studies on the patient care pathway which could be conducted following discharge, either through questionnaires or telephone interviews. This may help hospital management to examine and plan practice, whilst improving the patient care pathway.

Findings in this study revealed that some HCPs, as well as patients, are unaware about certain community services. HCPs reported the difficulties the patient may encounter whilst trying to make use of such services, which include limited community resources, lack of human resources and a waiting list. This is similar to the findings of Connolly *et al.* (2010) who found that HCPs strongly agreed that discharge could be improved in practice, by improvement in community services. Further results showed that HCPs acknowledged the need for educating older adults about the available community resources, as well as, the appropriate use of such services. HCPs also suggested further community services which may be worth considering in view of minimising the risk for institutionalisation. Since there appears to be unawareness about community resources, the researcher's role in the future is to raise awareness amongst HCPs about the available services. This can be achieved by organising continuing education updates with HCPs about the available resources. In addition, the nurse preparing the patient for discharge should inform the patients and their ICs about these available resources. When required, the nurse should involve the social worker who is able to inform the family and who can eventually help the patient to submit an application for the required service.

The need for further education on the rehabilitation process was also regarded by the HCPs as crucial. This is due to the fact that the patients who participated in this study all expected a convalescence period at the rehabilitation hospital, irrespective of whether it was needed or not. This finding highlights the need for more clarity and further supports the need for continuous practice development courses for HCPs to inform them on the community services which are currently available. This clearly indicates that a nationwide campaign is required to inform the general public about available resources and their proper use. For example, older adults using Telecare/Emcare services should be encouraged to wear the call button at all times.

Participants also defined intermediate care as the setting which serves as a link between acute care and community. HCPs revealed that this helps to decrease hospital problems, to enhance continuity of care and promote independency which in turn, decreases institutionalisation. In this study, HCPs observed that although intermediate care may be difficult to implement due to lack of financial/human resources, its introduction would decrease the beds at the rehabilitation hospital. Similar findings by Dahl *et al.* (2014) found that HCPs viewed discharge through intermediate care positively when comparing it to discharge to primary care.

This section discussed the findings in view of the second objective which was about identifying factors influencing the care of fractured femur patients. These findings were important because stakeholders helped with problem identification and lead to the recommended solution which was the development and introduction of an information booklet distributed to fractured femur patients soon after admission.

7.6 Stakeholders' involvement in the care of fractured femur patients

The ultimate objectives of this research study were **to analyse the readiness for change and explore the views of the stakeholders on the provision of the information booklet.**

It also evaluates the stakeholders' impact on the information booklet developed for patients with fractured femur, their ICs and the MDT.

It included three themes:

- Communication / information gaps in care pathway;
- Participants' views on use of information booklet;
- Information booklet as perceived by patients and ICs.

7.6.1 Communication / information gaps in care pathway

Issues identified in the main findings in this study which were frequently discussed by participants were lack of information-giving on the care pathway, lack of involvement in decision-making and communication issues. Additionally, during the focus group discussion it was found that HCPs acknowledged the lack of information. They commented that they failed to introduce themselves to patients whilst stressing that it is the patients' right to know who is taking care of them. This was consistent with the Maltese Charter for Patient's Rights and Responsibilities which states that a patient has the right "to be told the names and roles of the healthcare providers responsible for one's care" (Patient's Charter, 2016, p.10). This finding is similar to the studies conducted by Wong et al. (2011) and Okoniewska *et al.* (2015) who found that the lack of professionals' role identification was the most common barriers towards communication in the patient care pathway. This may suggest the need to raise awareness amongst HCPs about the importance of introducing oneself and of building a rapport with patients. Once this straightforward change in approach is achieved, patients would be better informed about who is looking after them and a relationship is established. The more complex aspect of achieving an effective patient care pathway would then be possible. This is beneficial for both the professional and the patient.

HCPs in this study mentioned the inconsistencies in information-giving about care and the lack of clarity on the role of specific discharge groups. Nevertheless, HCPs in this study divulged that the recent introduction of various discharge groups is causing fragmentation of hospital services. This may be because locally, the discharge process is still evolving and until recently was not given its due importance. Therefore, following an audit by Johns Hopkins University in 2012, a number of initiatives were introduced. The introduction of two services, namely the discharge liaison nurses and the discharge facilitation team, had confused HCPs.

Consequently, there is a need for continuous practice development courses which should include updates on the different roles of these discharge groups.

An unexpected finding in this study was that HCPs talked about patients' cultural variations when it comes to self-care. Professionals disclosed that Maltese older patients tend to be more dependent in their needs on the staff when compared to other patients admitted with hip fracture from other countries (tourists). This may be because patients claim that since they are paying taxes they expect to acquire what they want, based on their desires rather than what their needs really are. In addition, patients and their ICs do not view the hospital as an acute hospital but they expect to stay until reaching their previous functional status. This suggests the need to educate the general public about the function of the acute hospital and the rehabilitation hospital. It is also important to educate older patients on how to keep independent and healthy, even after experiencing a fractured femur. ICs tend to overprotect the older patient and unknowingly encourage dependency by doing things for them, rather than encouraging them to self-care. The same happens with HCPs who help patients too much to get the job done quicker. Another rationale for this finding may be that historically, Malta was under the rule of various powers and as a nation, it only acquired its independence in 1964. It is the researcher's experience that the older Maltese generation is generally more dependent on family and HCPs than foreign patients.

HCPs stated that there is a need for reassurance during the patient care pathway which can be achieved through information-giving. HCPs in this study felt the need to inform patients on admission that their rehabilitation programme is initiated at the acute hospital and continued at the rehabilitation only when required. Yet again, these findings disclose the need for information-giving about the functionality of the two hospitals since patients perceive that their rehabilitation period starts following transfer to the rehabilitation hospital. There is also the need for better management of beds in both hospitals, since patients can only be transferred to the rehabilitation hospital once a bed is available. Therefore, the patient might have recuperated so well that s/he might go home before being transferred to the rehabilitation hospital but because a decision has been taken, it is rarely reversed. This may suggest the

need for further studies to obtain a real picture of what is happening and change should occur for the benefit of both the patient and the hospital.

Finally, patients discussed their lack of awareness of what to expect and what is expected from them during their journey. Yet again, the lack of information-giving and communication was found to be the main findings in this study. Hence, patients explained that information-giving is important, whilst they argued that HCPs should treat patients as if they know nothing. Findings from different studies consistently showed that the most perceived need stated by patients and their ICs, and which generally is not met during the rehabilitation process and in the immediate post discharge phase, is the desire for more information (Olsson *et al.*, 2007; Johnson, Sanford & Tyndall, 2008; Allen *et al.*, 2013). Hence, the need for the development of an information booklet was suggested by the majority of the participants. The information booklet's development was achieved through participation and collaboration of the stakeholders. This was further explained by the Habermas theory which explains that active participation is an important process in open communication and collaboration

7.6.2 Participants' views on the information booklet

An important finding was that all patients and their ICs stated that they had read the information booklet with most reading it sequentially. Further findings were that patients and ICs argued that the booklet is always available and is a reliable source. They discussed that Maltese people tend to rely on other people's stories rather than searching for the correct information from HCPs.

Younger generations are more likely to refer to the internet where an enormous amount of the required information is easily available. However, older generations in Malta are not usually so familiar with the internet. Also, virtual information may not always be reliable enough and it does not reflect local practice due to cultural variations and hospital policies. Furthermore, Kennedy *et al.* (2017) reported that although web information has increased, it has not necessarily brought about an improvement in understanding. This entire information search may be due to a lack of available resources at point of care. The lack of written materials in clinical

practice and the need for improvement were highlighted over the years by various researchers (Demir, Ozsaker & Ilce, 2008; Choi, 2011; Frojd *et al.*, 2011; Tsui *et al.*, 2015; Kennedy *et al.*, 2017).

According to previous literature and this study's findings, the use of the information booklet enhances communication and decreases fear. It shows that it helps patients to communicate better with the MDT and improves understanding of the role of each member. Surprisingly, the findings also showed that the booklet helped older patients in their communication with their family members by explaining about their surgery. One can immediately notice that the majority of the stakeholders prioritised communication throughout this PAR cycle. Although, some patients seemed to excuse HCPs for the lack of communication, findings showed that the booklet had improved patient and HCP communication. This finding is somewhat similar to the findings of Digby and Bloomer (2014) who found that those patients who identified a single HCP established better satisfaction with communications when compared to those who did not. Another study supported this finding whereby a significant improvement was found with improved patient communication after more patient knowledge about their caring professionals (New, McDougall & Scroggie, 2016).

A surprising finding in this study which complemented the influence of culture on patients was that the booklet did not help patients in decision-making about their discharge. A rationale for this finding could be because patients trusted and believed that decisions should be taken by the experienced HCPs. In addition, the fact that the booklet was not distributed prior to surgery might have influenced the results. However, the nature of the Maltese older patients being culturally attached to entrusting HCPs with decision-making about their own health was frequently discussed during this PAR cycle. This cultural issue in relation to evidence was discussed in Section 7.4.2. With the introduction of the booklet more has been generated since it made a difference in ICs' life and helped them to reduce anxiety. The fact that they were provided with telephone contacts, reassured them and was very useful following patient discharge. This is similar with the literature findings where patients and ICs specified that receiving comprehensive information through pamphlets, booklets or telephone follow-up were more satisfied and viewed this as a

form of support for the care-giving role (Mistian & Poot, 2008; Boughton & Halliday, 2009; Rennke *et al.*, 2011).

All participants agreed that the pictures were beneficial for HCPs because they assisted them when informing patients while patients commented that they facilitated understanding especially with individuals who couldn't read. Participants talked positively about the layout and the content by explaining that the booklet was devised very well, it is easy to read, with good use of colours and that the sections and font and size selected made reading easier. Participants also found that the booklet was user-friendly and the language used, especially the Maltese, was easily understood by patients and did not use jargon. This is in line with the literature, which recommends that if written material is to be effective, the contents should be simple, understandable and with good use of photographs, charts and computer illustrations (Aldridge, 2004; Demir, Ozsaker & Ilce, 2008; Peregrin, 2010; Shepperd *et al.*, 2013). Other important considerations were the use of a large font, contrast between the printing and the background and spacing (Griffin, Mckenna & Tooth, 2003). Furthermore, it is recommended that educational information should consider the cultural aspects of the population (Aldridge, 2004). Although this might seem to have been discussed more than a decade ago, this is still a beneficial consideration due to the influence Maltese culture has upon older citizens. This is still valid in current practice. Hence, one of the reasons of including all stakeholders in the development of this booklet was that it was developed from the service user and HCPs to the general public, all of whom are living within the same cultural context. Besides, Kennedy *et al.* (2017) reported that there is strong evidence that patients' and ICs' involvement is advantageous when developing and evaluating health information material.

The HCPs concluded that all useful information was included and the layout enhanced readability. Participants also agreed that the language used (both the Maltese and the English) was understandable, despite the issues of limited vocabulary which often occurs when trying to find the right medical terms in the Maltese language. The literature provided an insight into the numerous tools used for assessing readability such as, SMOG formula (McLaughlin, 1969 as cited in Monsivais & Reynolds, 2003) and Fry Graphs (Fry, 1977 as cited in Monsivais &

Reynolds, 2003), Flesch Reading Ease Score (Flesch, 1947 as cited in Mumford, 1997) and Gunning Fog Index (Gunning, 1968 as cited in Mumford, 1997). This suggests that the development of this booklet needs to be further evaluated, using some available tools, to ensure that the booklet is readable by older fractured femur adults. This is imperative since there is evidence that most of the patient information on major orthopaedic material available on the web is written at an advanced level and is not generally comprehensive to most (Badarudeen & Sabharwal, 2010).

When discussing the content of the booklet, some patients and ICs concluded that nothing should be changed but there should be a summary of the booklet. This is contradictory to the HCPs' findings. Although, the HCPs acknowledged that the booklet seemed thick, all HCPs felt that nothing was extra and did not want to change anything. These findings suggest that there is a need for further reflection and discussion amongst the stakeholders about the possibility of developing a summary of the booklet. An unexpected finding was that patients mentioned that since they were able to keep the booklet, they could read it at any time at their own pace. The majority of the patients and ICs suggested further information on various topics, such as more information on surgery, osteoporosis, HCPs' role and exercise instructions of the physiotherapist. Only one IC reported that the booklet was too long for older patients. Although the majority commented that there was no need for any extra information, this does not mean that the booklet is complete. This suggests that a detailed exploration involving a larger sample should be considered after the booklet has been used for some time in clinical practice. Any changes should be implemented and the booklet should be continuously reviewed. Furthermore, the researcher's role is to identify and develop a plan about further implementation of the information booklet in clinical practice. As the information booklet was developed by all stakeholders, especially service users, it is important that its use is further evaluated for a second time by all stakeholders. This will ensure that it is understandable, sustainable and can be utilised in practice by everyone in order to enhance the care pathway of fractured femur patients.

Some of the patients and their ICs suggested that the booklet should be divided into two parts namely; preoperative and postoperative. Others added that the fall prevention part should be distributed to all older adults in the country, as part of a

national educational campaign. There was a disagreement amongst HCPs about separating the booklet with some arguing that patients should be given the discharge instructions only. This was counter argued that if the booklet were to be divided, it would not achieve its purpose. This divergence may be due to the fact that individuals are different from one another and people have different opinions. Another reason for this disagreement may be because some patients are not so interested to receive information, whilst others need to know everything. Therefore, the division of the information booklet is still inconclusive. This suggests a need for further in-depth exploration to determine why participants suggested to have the information booklet divided. Participants did, however, comment that it was better to have more information than not to have enough.

Feedback from HCPs on the use of the information booklet showed that one of the problems encountered was the distribution time of the information booklet. Most HCPs suggested that the booklet should be handed on admission, once the patient has settled in the ward. Likewise, patients and their ICs insisted that the booklet should be handed out prior to surgery. It was agreed between all stakeholders that if the booklet is handed to patient on admission it could help decrease anxiety. This is supported by the literature indicating that the most requested information was related to anxiety creating factors (Lithner & Zilling, 2000) whilst written and verbal information was found to decrease anxiety by making the unknown familiar (Lam *et al.*, 2001; Spalding, 2003; McDonald *et al.*, 2014).

This study reached similar conclusions because patients and ICs expressed that if the information booklet had been given earlier they would have been more prepared for their journey and the information would have been more effective. However, this does not disregard the fact that patients are admitted to hospital unexpectedly, thus preoperative preparation time is limited. So, in these circumstances, the information booklet may help patients and their ICs to receive the right information at the right time. This may also help older patients and their ICs to receive consistent information, since information could vary from one healthcare professional to another. Therefore, if the patient receives the right information and HCPs are guided by the booklet, inconsistencies in information-giving may decrease. Moreover, this

suggests the need for the development of an information guide based on the booklet with the aim to standardise information given by HCPs as much as possible.

This study findings conveyed that there are various advantages to be gained by distributing the booklet on admission. Primarily, participants shared that patients and ICs are not given any documents on admission as in the discharge process, so there will be less confusion with all the papers. Secondly, the booklet contains information which commences with hospital admission and continues until discharge into the community. This information is likely to be useful during the patient's hospital journey. Distributing the information booklet on admission will allow patients the ability to refer to information when required, use the booklet to learn at their own pace and clarify any queries. This finding correlates with the literature which found that for successful discharge, information should be shared between patient, family caregiver and provider from admission through to post discharge (Naylor & Keating 2008; Archie & Boren, 2009; Augustinsson & Petersson, 2015).

The other issue was on further emphasis in the booklet on educating the public to keep within the visiting hours. There was a lot of agreement amongst almost all stakeholders about the importance of educating the general public about these visiting hours. An explanation of this result was that participants felt that patients needed time to rest and too many people near one patient may disturb others in the same room. Such findings may be due to the fact that visiting hours within the last year have been extended in the acute hospital in Malta, which might have had an impact on the HCPs' argument since HCPs did not view this change positively. However, evidence indicates that extended visiting hours or open visiting policy enhances family visits, may improve quality of care and encourages family engagement in improving patient outcome (Venkataraman *et al.*, 2015; Muscat Baron, 2016).

Consistent with literature, HCPs discussed the importance of involving relatives when distributing the booklet since if family members are involved they can help the patient to prepare more effectively for their journey. The distribution of the booklet to ICs can be very useful when caring for patients with cognitive problems, especially when they are unable to comprehend the information.

7.6.2.1 Advantages of introducing booklet to fractured femur patients

An essential part in Phase 3 of this PAR cycle was the evaluation of the information booklet which included use and presentation. Therefore, the stakeholders of this study identified that the implementation of this booklet had several advantages:

- Provides of a good source of information to patients and their ICs and informs them on how the hospitals function.
- Provides patients and ICs with a better understanding about the type of surgery and helps them understand consultants' explanation.
- Facilitates communication between patients and HCPs.
- Helps nurses to focus and guides them when giving discharge instructions whilst facilitating patient understanding.
- If information is unintentionally missed; patients can refer to it.
- Avoids conflicting information which may decrease patient confusion.
- Verbal information is supported by written information.
- Provides further knowledge on the care pathway and on how patients can identify and avoid complications.
- Acts as a point of reference for the patient throughout their journey from admission and until discharge home. The provision of information such as contact numbers etc. was considered as reassuring, especially for those older patients who live alone.

These advantages are similar to what is to be found in international literature on the benefits of an information booklet (Mistiaen & Poot, 2008; Choi, 2011; Schmidt, 2013; Langford *et al.*, 2015; Tsui *et al.*, 2015; New, McDougall & Scroggie, 2016). In fact, Coulter and Ellins (2007) state that evidence from reviews revealed that carefully designed written information can be a beneficial adjunct to HCPs and can improve patients' health knowledge and recall. As well as all the benefits mentioned by HCPs on the introduction of the information booklet, nurses also acknowledged that the booklet would guide them in practice.

Nurses in the focus group greatly acknowledged the benefits of the booklet. This may be because, as revealed in this study findings, the shortage of nurses might have

led them to put aside or spend less time educating and communicating with older patients. Therefore, its use may also be beneficial to the nurses' role when providing information to patients especially prior to discharge. However, one needs to be cautious when interpreting these findings because the information booklet must not substitute verbal information but preferably be a complimentary aid. This was emphasised by HCPs who reiterated that their aim would not be reached if they just gave the booklet without explanation whilst they considered it as a team effort. This was further substantiated by the majority of the patients and their ICs. Coulter and Ellins (2007) explained that educational leaflets on their own have little effect unless combined with verbal information-giving which proved to reduce health services resources. Therefore, to avoid this from occurring in practice, continuous auditing or research on the use of the information booklet should be conducted to monitor its utilisation, impact and whether any changes are required.

7.6.2.2 Feasibility of introducing booklet to fractured femur patients

Another finding discussed by participants was the cost of the information booklet. HCPs recommended that the hospital should invest money for that kind of information since it was perceived as beneficial. Although, the attainment of sponsorship was debated, the idea was rejected because of ethical issues. Besides, there is the nurses' responsibility in ensuring that the HCPs' status is not used to advertise commercial products or services (Maltese Code of Ethics for Nurses and Midwives, 1997). Sponsorship sustainability is questionable since the information booklet was planned to be used in clinical practice for an indefinite period. However, considering the cost versus the benefits, it could be argued that benefits far outweigh the costs. It may further be noted that information would have a positive effect on the quality of the services provided. It was found that interventions promoting health knowledge through the use of educational material has several advantages, such as positive health outcomes; decreased use of health services (Coulter & Ellins, 2007); improved readiness by family members to provide care to the patient (Schmidt, 2013) and better health behaviours (Langford *et al.*, 2015).

Concern about patients actually reading the information booklet was another perceived problem by a very small number of HCPs. Conversely, the majority believed that patients would read the booklet. Two patient categories were identified;

those who would completely ignore it and those who would read it all. Thus, there seems to be inconsistencies in the findings amongst HCPs about the utilisation of the information booklet. The HCPs' reasoning was that there is always going to be a small number of patients who are reluctant to be proactive in their healthcare. This may be since patients are not always interested to know about their care pathway or that information may actually cause more anxiety. The Maltese Code of Ethics for Nurses and Midwives (1997, p.9) states that "patients who wish not to be told certain things and who prefer to leave everything in the hands of their carers whom they trust to do the best for them, should have their wishes respected." Despite this, literature constantly identifies that the provision of an information booklet was effectively utilised by older fractured femur patients (Suner *et al.*, 2010; Chamberlain & Pugh, 2015; Tsui *et al.*, 2015).

Another dilemma regarding the use of the information booklet was with patients with cognitive and literacy problems. HCPs' findings suggested the following solutions: ICs or voluntary staff involvement; use of other media resources such as videos or audio recordings and the use of pictographs. Additionally, there was a disagreement amongst participants about the use of pictograms because they argued that it may be viewed as humiliating or childish for older patients. However, this is in contrast with the findings of a narrative review including 44 studies, which found that the use of pictographs with older adults with low-literacy skills were found to be the most useful and effective tool to enhance discharge education (Choi, 2011). In another study, the use of pictographs helped people remember verbal instructions (Houts *et al.*, 1998). It has the capability to surmount communication barriers whilst offering the necessary information (Doucette *et al.*, 2014). These mixed findings suggest the need for research on how other modes of information-giving, besides the written format, can be enhanced in older patients with low literacy skills in Malta.

Participants suggested two important changes in order to improve the booklet and its use. They suggested that there should be space where the name of the caring consultant should be documented. This suggestion is feasible and can be easily implemented, since the patient is taking the booklet with him/her and there is therefore no breach on data protection. This supports the fact that patients have the

right to be told the names and roles of HCPs responsible for their care (Maltese Charter of Patients' Rights and Responsibilities, 2016).

7.6.2.3 The importance of fall prevention

A fall prevention national campaign was suggested by the majority of participants with HCPs aiming to also reach older adults in institutions. They recommended various means for reaching the older population, which included video clips, talks, television and radio programmes. ICs recommended that the sections on fall prevention should be summarised and distributed in public places and placed in waiting areas. This suggestion should be carefully considered by the Health Department in Malta because increasing safety and maintaining a healthy lifestyle is critical to reduce the rate of falls. Raising awareness and educating the general public on home safety and prevention of falls is important since statistical data shows a consistent increase in hip fractures as a result of falls (WHO, 2010). In fact, 58% of injury-related admissions to the emergency department attendances for older people within the European Union countries are mainly due to falls (Turner, Kisser & Rogmans, 2015). Besides, falls can have serious consequences on the older adult's health, mostly due to loss of independence. This can be easily prevented with minimal changes in an older person's life. Moreover, the researcher's responsibility following this study is to raise awareness about a fall prevention campaign in Malta, which has been given a high priority by all participants, especially the participatory action group. Awareness can be raised by the researcher by continuing a post-doctoral research programme or by encouraging possible researchers to embark on further research on a falls prevention campaign in Malta.

7.6.3 Measures taken by patients / ICs after reading the booklet

When asked whether they referred to the booklet after discharge, the majority referred to it for information on leg swelling since they were concerned about it. This illustrates that the information booklet can be used as a source of reference after discharge. It would be interesting to explore the utilisation of such a booklet by patients and their ICs over time.

The findings also identified actions taken by older patients after reading the fall prevention and health promotion section. Patients commented that they read the fall

prevention section since they were overwhelmed by the fear of sustaining another fall. Although ICs did not suffer any falls they decided to take precautions themselves and also for their relatives and avoided the hazards mentioned in the booklet. They also mentioned not knowing about the importance of regular eye and hearing tests in order to avoid falls. This is consistent with other findings which found that when older patients are advised about fall prevention, they experienced less falls and improved recovery (Shyu *et al.*, 2010; Kristensen *et al.*, 2016).

Patients also commented about learning more about osteoporosis. The fact that participants read and decided to take action to prevent falls showed that information-giving can have an impact. Therefore, this suggests the need for a well-planned national fall prevention campaign. Continuous professional courses for HCPs should be organised to further enhance their communication and information-giving skills. Nurses should be encouraged to attend these courses since they are continuously with the patient so they should keep abreast with recent evidence on best practices.

7.7 Conclusion

A PAR cycle was conducted with stakeholders using a basic AR routine cycle ‘LOOK’, ‘THINK’ and ‘ACT’ by Stringer (2014). In Phase 1 (‘LOOK’ Phase) participants identified a need for more information-giving throughout the journey of an older patient with fractured femur. The identified solution was the development of an information booklet which was discussed with a group of participants in Phase 2 (‘THINK’ Phase). In Phase 3 (‘ACT’ Phase) in this PAR cycle, the proposed information booklet was subsequently developed, implemented and evaluated in clinical practice.

The booklet was developed on what the stakeholders suggested in Phase 1 and this was developed in order to enhance the journey of those patient who had experienced a fractured femur from admission until subsequently being discharged into the community. Few research studies have considered including the service users and caregivers in research studies in the care of older fractured femur patients (Foss & Askautrud, 2010; Rout *et al.*, 2010; Toscan *et al.*, 2013).

Findings from this PAR Cycle showed that there are problems with the provision of care since it was determined that more than half of the patient participants were being cared for by another older IC, many of whom found it difficult to cope with their own ADLs, let alone their frail relatives. Although the caring role of the Maltese family is changing, this study provided evidence that family assistance is still exerted in times of need.

Findings in relation to the first objective reported stakeholders' perceptions on the patient care pathway. Although most patients were satisfied with the care given, various undesirable comments were mainly about lack of psychological support, lack of inclusion in decision-making, postponement of surgery and lack of information-giving and discharge planning. In relation to the second objective, one can immediately notice that the cause may be due to communication difficulties between service users and the hospital system.

The medical model dominance was evidently demonstrated with this study's findings, which found that consultants could discharge patients on the same day, without proper discharge planning. Also, there is still a cultural issue amongst older Maltese patients, where they believe that decisions are to be taken solely by the doctor and they, as the patients, need to abide by them. According to Habermas (1987), this conflict between the patient 'lifeworld' and HCPs as part of the hospital 'system' has contributed towards the above problems. Therefore, through the Habermas (1984) TCA, a communicative space was created where all stakeholders identified lack of information-giving as the main problem. Following the development of the information booklet with the help of the stakeholders, it was implemented into practice for further evaluation.

Finally, whilst attaining the ultimate objectives of this research study, it was found that the implementation of the information booklet had its benefits, as well as its disadvantages. Various issues were discussed such as distribution time; financial aspects of sustaining it; readability and comprehensibility; importance and use of the booklet and measures taken by participants after reading the information booklet.

Supporting the booklet with verbal information was significantly given its due importance by all stakeholders. Obtaining perceptions from stakeholders and their contribution in developing this booklet enriched the findings and contributed towards obtaining a realistic view on the care pathway of older patients with fractured femur. Consequently, some suggestions for recommendations, for hospital management and for further research are proposed to further ameliorate the journey of fractured femur patients, from admission to hospital to recovery and discharge into the community. These are to be found in the final chapter.

CHAPTER 8

CONCLUSION

8.1 Introduction

This chapter presents a summary of the research and outlines the key findings of the study. This study's contribution to the body of knowledge and recommendations which emerged from it will also be presented. This chapter discusses the study's strengths and limitations and ends with a reflection on the learning journey that was experienced by the researcher.

8.2 Summary of the study

Various studies have been conducted on the care pathway of patients with a fractured femur but there is a lack of studies which include the patients, ICs and HCPs and where they participate in the entire research process. The researcher identified that, previously in Malta, no research studies had been conducted using an Action Research (AR) design in the care pathway of patients admitted to hospital with fractured femur. It was within this perspective that the need for an in-depth study has been undertaken. Hence, the overall aim was to enhance the patient journey for those who have experienced a fractured femur from admission to hospital to recovery and discharge into the community.

A Participatory Action Research (PAR) study was conducted where decisions about what to explore and what needs to be changed were taken collaboratively by the stakeholders. This PAR Cycle was guided by the Habermas (1984) Theory of Communicative Action. This theory helped participants to open a communicative space, identify a problem whilst providing a solution. This research followed three phases which incorporated a basic AR routine cycle of 'LOOK,' 'THINK' and 'ACT' (Stringer, 2014).

- In **Phase 1 (LOOK Phase)** a three month quantitative data was selected to obtain baseline data. The research facilitator then identified the stakeholders to be older fractured femur patients, their ICs and HCPs. Through one-to-one interviews, the stakeholders' perceptions and their shared concerns were identified.
- In **Phase 2 (THINK Phase)** informal communication with the PAR group was achieved whereby lack of information was identified as a concern by all stakeholders. The research facilitator communicated with a PAR group and following data analysis of Phase 1, it was decided that there was a need for more information during the patient journey from admission until discharge into the community. This led the group, together with the research facilitator, to create an information booklet for older patients with a fractured femur and their ICs.
- The information booklet was developed, implemented and evaluated in **Phase 3 (ACT Phase)**. During this final phase, semi-structured interviews with another group of patients and their ICs were organised to evaluate the booklet. In the case of HCPs, this occurred through focus groups. These group discussions were conducted with the same HCPs who had participated in Phase 1 and Phase 2, respectively. These HCPs provided continuous collaboration as a multidisciplinary team in practice in this PAR cycle.

A key finding in this study was the lack of information-giving to older fractured femur patients and their informal carers. HCPs acknowledged the lack of information-giving and supported the development of the information booklet.

8.3 Concluding comments on the findings of this study

In conclusion, stakeholders acknowledged that the implementation of the booklet had several advantages - that it was a good source of information; verbal explanation was supported by written information; it enhanced the patients' knowledge; avoided inconsistent information; facilitated communication; was a guide for HCPs; facilitated patient understanding; and served as a source for future reference once the

patient was discharged. HCPs emphasised that information-giving would not have been effective if they had to just give the booklet without any verbal explanation, whilst the process was considered a team effort. This was further substantiated by most patients and their ICs. It was determined that all patients and their ICs had read the booklet sequentially and that the majority of them had referred to the booklet after discharge. Maltese people often tend to collect information through other people's stories, even though they may not be accurate or relevant to their case. It was demonstrated that the booklet could overcome this and offer a reliable source of information which is always available for reference. An important finding was that the booklet helped patients to better communicate with HCPs and understand the team members' role. Surprisingly, the booklet was also found to help patients in their communication with their family.

The booklet made a difference to the ICs' life as it helped them to overcome their anxiety due to the provision of contact numbers, which reassured them following patients discharge. The participants talked positively about the layout and the content by explaining that the booklet was designed very well, it was easy to read, with good use of colours and sections also and that the font and size selected made reading easier. Participants also found that the booklet was user-friendly due to the language used, especially the Maltese version, which was easily understood by patients without the use of jargon. HCPs concluded that all the necessary useful information was included and the layout enhanced readability.

Stakeholders agreed that with regards to content, nothing should be changed, but some suggested that the booklet could be divided into two parts namely preoperative and postoperative. Participants added that the fall prevention section should be distributed to all older adults in Malta as part of an educational campaign. Patients disclosed that they had read the fall prevention section since they were extremely fearful of sustaining another fall. Although ICs had not experienced any falls personally they had decided to take precautions for themselves and for their relatives. It was interesting to note that all precautions mentioned were hazards presented in the booklet whilst ICs talked about their unawareness about regular eye and hearing tests. The fact that participants read and had decided to act to prevent

future falls clearly illustrated that information-giving can have a positive impact on the patient and their ICs.

Finally, the researcher was able to determine these important findings due to the participation and collaboration of all stakeholders throughout this PAR cycle. All this was possible as a result of the usefulness of the selected methodology.

8.4 Originality and contribution to the body of knowledge

Conducting a PAR study provided a unique opportunity for patients, ICs and HCPs to participate collaboratively to enhance the fractured femur patient's journey from admission until discharge into the community. This study was the first of its kind in Malta in clinical practice and provided an in-depth knowledge on the patient care pathway. It provided the possibility to prove that patients and ICs can contribute and are valuable participants in research and to future nursing practice. It demonstrated that if patients and ICs are allowed to be involved, they can help HCPs and the hospital management to question and/or improve practice.

AR provided the stakeholders with an opportunity to be proactive in identifying the problem themselves and to work towards finding a solution, rather than the research process being planned in advance by the researcher. The research was conducted *with* the stakeholders rather than about them, whilst it was an encouraging and empowering experience for stakeholders to make important decisions in all stages of the PAR Cycle. It offered an opportunity to assist patients and informal carers to understand and participate in the care pathway of a fractured femur patient. It also assisted HCPs to question and enhance their practice. In particular, this study identified the stakeholders' needs and helped them to enhance practice by providing rich information on the stakeholders' perceptions. It provided participants with the opportunity to open a communicative space and work collaboratively to reach a common aim - the enhancement of the fractured femur patient's journey to recovery. Enthusiasm was demonstrated by the stakeholders' willingness to participate since most of the participants who had been invited to participate accepted immediately.

The study provided all stakeholders with the opportunity to decide and examine hospital rituals and question practice through reflection and questioning practice both at an individual level, at ward level and more broadly on a hospital organisational level. Providing a consensual and participatory approach enabled stakeholders to identify the problem by prioritising the important issues for them in practice. It also provided an opportunity for all stakeholders to reflect and discuss their experiences and to devise an effective plan to enhance the patient care pathway. Moreover, it was an educational and learning experience for all stakeholders which facilitated dialogue towards more patient-centred care by taking into consideration the views of both the service user and the service provider.

This PAR study has made an important transfer of knowledge into practice by decreasing the gap between research and practice. It has also provided knowledge on how practice can be improved by the use of evidence. This study shed light onto the influence of local culture in relation to local clinical practice. This presented a wider understanding on the perceptions of older patients and their ICs within the community. As a result, a clearer picture on the nature and reality of patients' informational needs and how patients perceived their role in decision-making during their hospital journey was achieved. This study further provided knowledge about the use of the information booklet which was found to be beneficial and was given a great deal of importance by stakeholders, despite being in an era of enormous technological advances.

An important contribution was made to research by minimalising the power inequality. Information was exchanged with all participants since all were regarded equally. This study challenged past behaviour by HCPs when planning or developing educational booklets. These were routinely developed by HCPs, however without the participation of service users. Finally, it demonstrated the need to raise awareness amongst HCPs that information-giving to fractured femur patients is an ongoing need in today's modern healthcare.

8.5 Recommendations

In conclusion, some recommendations are presented here with the aim of improving practice and service provision through the increase of evidence, continuous research and education on this subject. It is hoped that this will continually enhance the fractured femur patient's journey from admission until discharge into the community.

8.5.1 Recommendations for clinical practice

A number of recommendations were identified through this study:

- Since there are no guidelines in practice, the local hospital should develop written guidelines on hip fracture management which would help HCPs improve patient care. The development of local guidelines is important and the use of various evidence-based guidelines have been found to be beneficial in other countries for the management of hip fractures, such as SIGN (2009) and NICE (2011).
- The rights and responsibilities of all stakeholders should be taken into account in the development of standardised discharge planning guidelines for trauma wards. The standardisation of the discharge process with stakeholders' involvement will prevent inconsistencies in advice being given to patients.
- An identified informational need was that participants felt the need for more information on pain relief medications. Thus, it is recommended that on discharge, a pharmacist should create a form incorporating clear instructions about the treatment that the patient needs to continue once discharged. This will enhance compliance with medications, decrease medication errors and increase patients' and ICs' knowledge.
- As all HCPs acknowledged the importance of communication amongst team members, it is recommended that there should be staff activities including team building exercises to further enhance collaboration and teamwork. This could be

organised at ward level by organising activities on how to nurture teamwork and understand team dynamics.

- There is a need for the development of support groups which may help patients and their families to share experiences with other families.
- This study has highlighted that individuals who have experienced a fractured femur and their ICs need to be represented by organisations for older people. This is especially important, when serious adjustments to family life are required, such as in the case when the family caregivers, who are often elderly themselves, are responsible for the care of their frail relative.
- Findings in this study showed a lack of information about community resources and their inappropriate use. Thus, it is important to inform the general public about the available community services and about their proper use, such as wearing the help call button at all times when utilising Telecare/Emcare services, etc.
- There is a need to raise awareness amongst HCPs about the available community resources. This can be achieved by organising ward-based educational courses, which can continuously update HCPs about the proper use and availability of community resources.
- It is recommended that there is a need for the education of the general public in Malta on the functions of the acute and the rehabilitation hospitals. In that the rehabilitation process starts at the acute hospital and to be continued at the rehabilitation hospital only if required. This recommendation should clarify the concept of what is rehabilitation since all participants in this study perceived the need for a convalescence period at the rehabilitation hospital irrespective of whether it was needed or not.
- There is a need for a national fall prevention campaign amongst the older population. This recommendation should be considered as a high priority by the health department in Malta because statistical data has shown a consistent

increase in hip fractures as a result of falls. Participants recommended short video clips, television and radio programmes, various talks reaching older adults in the community and distribution of leaflets in public places. Also, the information provided in a national campaign should be based on evidence.

8.5.2 Recommendations for further research

This action research study has raised various issues and themes on the information-giving process throughout the journey of the older fractured femur patient. In this section, the researcher has outlined some recommendations for further research.

- A descriptive survey is suggested to investigate the impact this information booklet will have on patients and their ICs based on a larger scale and after prolonged use of the booklet in practice.
- A key recommendation was that the booklet needs to be further evaluated using readability formulas or tools (SMOG, Fry, Flesch Reading Ease Score and Gunning Fox Index) to assess that the booklet is user-friendly and readable for elderly adults.
- This study has focused on an information booklet as means of information-giving to the patients. Exploratory studies should be conducted on finding how other modes of information-giving, besides the written format, can be implemented in practice in older patients with low literacy skills.
- These findings identified the average length of stay at the acute hospital and patients talked positively about the impact that geriatricians had on their care pathway. Therefore, further research is recommended to explore the length of stay at the rehabilitation hospital and identify factors influencing patients' stay at the acute hospital. Moreover, a study on the impact of the rehabilitation programme and geriatric care on the older fractured femur patient is suggested to evaluate the programme in relation to the older patients' needs. This will allow local healthcare organisations to plan for future needs of the Maltese ageing population.

- The researcher identified a need for a longitudinal study to establish the extent of participation of Maltese patients and their ICs in the decision-making process in the care pathway of a fractured femur patient from admission until discharge home. Additionally, the socio-cultural impact on decision-making should be further investigated in this cohort since it was found to have influenced this study findings.
- A phenomenological study exploring the patients lived hospital experiences is suggested to offer greater insight into their fears and to examine specifically the communication process between patients, ICs and HCPs.
- It is suggested that the hospital should conduct evaluation studies on the patient journey immediately following discharge whereby data can be collected either through telephone interviews or questionnaires. The data obtained would help the hospital organisation to examine and plan care based on the findings whilst improving quality patient care. It also helps in the planning and provision of community services provided to older adults living in the community.
- As also highlighted by Troisi and Formosa (2006), there is a need for a detailed study to investigate the socio-economic conditions of the family caregivers in Malta. This should include an in-depth analysis on family structure and its changing role, with reference to the needs and difficulties arising from the changes in Maltese family structure and the impact this has on society.

8.5.3 Recommendations for education

In this section, the researcher presents some salient recommendations to enhance the training and education of HCPs and also presents some ways in which fractured femur patients and their ICs can be presented with more educational information to enhance the patient's journey to recovery. The final recommendation extends to the general public and highlights the importance of promoting prevention of falls

through a public information campaign which includes the distribution of educational material on this issue.

- Continuous professional development courses are recommended for HCPs to further enhance their communication and information-giving skills. Nurses should be encouraged to attend these courses for them to keep up-to-date with recent evidence on best practice and on how to educate older patients during their hospital journey. The subject of patient education should be given priority and be taught more in the undergraduate curriculum. Ward-based seminars and case scenario discussions should be regularly organised amongst the multidisciplinary team members to enhance a learning culture.
- There is a need for continuous education about the importance of listening to the patients, addressing their informational needs and empowering older adults to speak for their rights. This suggests the need for more continuing educational programmes including the need of reflective accounts which allow professional development, whilst identifying any changes that can improve clinical practice. The topic of information-giving and communication should be given more attention in the HCPs' curriculum, both in the undergraduates and postgraduate education. Seminars and conferences should be organised regularly for the MDT members and should be based on evidence.
- The inclusion of more reflection on clinical practice, where HCPs can examine their practice in relation to meeting the older patient's psychosocial and spiritual needs is another recommendation. It is recommended that HCPs should put more emphasis on holistic care during the patient journey by working on the patients' needs and values. This can be achieved by HCPs involving patients more in the decision-making and by spending more quality time with the patients.
- This study has shown that being able to refer to relevant information and educational material during the journey of a fractured femur patient to recovery helps bring about a positive outcome. The researcher therefore recommends that

steps are taken to promote this distribution of educational material to patients and their ICs.

- Prevention of falls is an important concept, both from the hospital's point of view, as well as from the individual patient's. Through the distribution of educational material to those who are most at risk of falling, as well as to the general public, the researcher recognises that this is an opportunity to totally avoid the serious consequences of having to deal with a fractured femur and therefore extends the individual's ability to continue living in the community.

8.6 Further evaluation of the booklet in clinical practice

Evaluation is imperative, especially when a service improvement and new initiatives are introduced in clinical practice (Reid *et al.*, 2007). From the start, the information booklet was developed with the involvement and feedback received from patients and ICs and was based on their needs and those of their families. The researcher also involved HCPs at every stage of its development. However, there is still a need to regularly evaluate the information booklet, especially after it has been used in clinical practice for some time. In this section, the researcher outlines a plan for the further evaluation of this booklet and also gives a brief review of its expected implications on the patient care pathway.

As mentioned above, it is envisaged that the implementation of the information booklet will eventually enhance the care pathway of the fractured femur patient. The researcher believes that an evaluation of this booklet after it has been used in clinical practice for some time, will ensure that it remains up-to-date and effective and would be an opportunity for stakeholders to share their experiences and their learning. This may be required due to changes in service provision, both at a secondary care and community level and would also involve reviewing and improving the content. Therefore, the plan should comprise one or more PAR cycles to further evaluate the booklet and its implementation in practice. These PAR cycle/s should include all stakeholders and should follow the three phases of a basic AR routine cycle of "LOOK, THINK and ACT" (Stringer, 2014). At this stage, the plan should include the senior management team so that the booklet would remain relevant and be utilised in practice. The involvement of the hospital management in this planning

phase is crucial due to the need of approval and to ensure its sustainability in practice.

The plan includes the following:

1. Conduct meetings with the hospital management to obtain approval for the implementation of the information booklet in practice and acquire their involvement in the PAR cycle/s.
2. The 'Look' Phase: Invite the MDT, patients and their ICs to participate in the PAR cycle/s. Create a group that is able to communicate ideas with the aim of organising meetings to plan the PAR cycle/s with them, This will include the implementation of the information booklet in the care pathway of the older fractured femur patient.
3. To decide with the group what methods of data collection are to be used and how many participants are to be recruited. The discussion should also include how and by whom data is to be collected and how it is analysed.
4. The 'Think' Phase will help to identify possible problems in implementing the booklet in the patient care pathway. Meetings with the participatory group in the 'Think' Phase will be organised according to the needs and further changes for improvement that will be decided. At this stage, solution/s to the possible problem/s identified should be communicated between the group members.
5. The 'Act' Phase: An agreement should be reached about when, how and by whom the information booklet should be distributed to fractured femur patients in clinical practice. During this phase, data will be collected again for further evaluation and if required, another PAR cycle will be repeated.
6. This plan should also include the implications the information booklet may have on the stakeholders when implemented into practice. These possible implications may address whether the booklet has had any impact on the

patients' length of stay, on the discharge planning process, on the level of engagement of the patients and their ICs in the process and whether it resulted in better communication. An additional implication which should be considered is the increase in bed availability in the rehabilitation hospital and whether ICs are and can be more informed about how to assist in patients' rehabilitation and whether more patients can be discharged home instead of to an institution.

8.7 Strengths and limitations of the study

The adoption of an action research study provided an opportunity to improve practice of the Maltese older patients with a fractured femur. Obtaining perceptions from all stakeholders about the patient journey enriched the findings and contributed towards obtaining a realistic view on the care pathway. An advantage of selecting a PAR study design was that it helped to identify the real problem of lack of information-giving in the patient journey. Whilst a solution was provided, through the development of the booklet, it allowed evaluation and modification throughout the entire project.

Further strengths of selecting an Action Research were that it helped to create an interest in research amongst participants, especially in HCPs and group participation and helped to motivate the group since HCPs were able to discuss complex issues in their practice. Action Research methodology encouraged self-awareness by all stakeholders by reflecting on the patient journey and results may inform others in a similar context and situation. Through Action Research, patients and their ICs were given the opportunity to be actively involved and be equal collaborators with HCPs. An additional strength was the patients' and ICs' involvement in the development of the information booklet and the content, as it was based upon their needs and not what HCPs think their informational needs should be.

The patients' and ICs' involvement was beneficial to this study, as the booklet was developed from the perspective of the service users and HCPs as well as that of the general public who are living within the same cultural context. Moreover, one of the major advantages of this study is that the information booklet (available in both

Maltese and English) will be used in the care pathway of older fractured femur patients. It is hoped that the use of the information booklet will help patients be more informed about various aspects of their care, resulting in a better outcome. From the aspect of HCPs, this study assisted them to consider how they were performing at various stages of the patient care pathway and helped them to identify where improvements were required.

Although the process was followed rigorously and all possible considerations were taken, there are some methodological limitations which require mention. Limitations included are that this study findings are generalisable only to the local situation and to those who are in a similar situation. Moreover, one of the limitations which are generally mentioned in the literature is that Action Research is very time consuming for little gain (Koshy, Koshy & Waterman, 2011). In fact, this study took quite a long time to identify the problem, to obtain ethical approval and to develop, implement and evaluate the booklet. As a PAR Cycle takes quite long to be established, the researcher was constrained by a lack of time and was not able to conduct another PAR Cycle to further change and evaluate the booklet. Another limitation was that it was difficult to measure change and more time was required. A larger sample would have helped to measure the full impact of the booklet on information-giving to older fractured femur patients. Another limitation was that more attention should have been given to Phase 2 (THINK Phase) by the researcher in this study. Collecting data through semi-structured interviews or focus groups could have enhanced this phase. However, because the problem was clearly identified the researcher felt that there was no need for further input by stakeholders on this issue.

Another methodological limitation was that AR was very dependent on collaboration. All stakeholders contributed wholeheartedly during the interviews and focus group discussions and accepted the invitation immediately. As patients had problems with mobility and pain, it was impossible to ask older patients to participate in group discussion. This might have limited the study findings.

All participants in all methods of data collection were offered the choice of selecting the language they preferred which enhanced participation and expression of participants views. A strength in this study was that the first interviews were conducted as pilot studies and were discussed with the research supervisors at each stage, it ensured that the researcher received feedback about my interviewing skills and that she was not adding bias to the data in the analysis. Also, the first focus group (the pilot study) was conducted in the presence of the local supervisor, who observed the discussion and gave feedback afterwards. Although, most translations were verified by professional academics in both languages, they could have been a source of error. However, the researcher is very fluent in both languages and was present at all interviews and focus groups so she was able to ensure that the translations reflected what had been said. Rigour of all data would have been improved if transcripts had been given back to all participants, instead of just a sample, to validate the credibility of the data.

A key limitation in AR that is frequently mentioned is that it lacks rigour and validity. All considerations were taken to avoid bias since the researcher was aware about my dual role namely; the role of a charge nurse and that of researcher. To decrease the impact of power a set of principles including “relationships, communication, participation and inclusion” developed by Stringer (2014) were utilised. These principles had helped me during the recruitment process and throughout the research process. The researcher’s position as a manager within the ward could have created power issues, thus to avoid this, she made sure that no authoritarian decisions were taken with HCPs and all interviews were conducted outside working hours to try and minimise bias, as much as possible. Being an insider could have been a disadvantage throughout the process but all precautions were taken so that she do not exert any coercion on the participants. Conversely, it could have helped to enhance the trustworthiness of the study due to a better understanding of both the participants and the environment. A positive rapport was established within the ward environment which was demonstrated by HCPs who agreed immediately to participate in this PAR study and persevered with the group until the final stages of this study. The stakeholders continuously showed genuine support throughout this journey.

8.8 Personal reflection

A journey of a thousand miles begins with a single step (Jansen, 2013). My journey started in 2008 when I had the opportunity to visit Wales on an Erasmus experience with the former University of Glamorgan. It was the beginning of a learning journey where I enjoyed working in various settings whilst the entire experience had a huge effect on my dream. My PhD journey, which was undertaken over a period of six years, started with positive thoughts and a desire to improve the situation of patients to whom I have dedicated my working life. This doctoral study was a learning experience which taught me a lot about research and how to apply research into practice. It has enhanced my appraisal skills, helped me to better understand older patients' experiences and subsequently bring about change in practice. Through this experience, I have nurtured my personal and academic skills and learnt to listen to others views. This action research study helped me engage with all stakeholders. Their contribution was very encouraging and empowered the group to reach its goal.

I compare this process with a journey on a train with its stations and sometimes with changing routes to reach my destination. At the beginning of this study, I boarded this train and as one does, met the same people on the train who were always there and who travelled with me on the same journey. There were the HCPs who are my colleagues and with whom I work on a daily basis. On the train, each day, we meet new people who are taking the journey. These represent the patients and family care-givers in the ward. These new people may also be professionals and managers who are not a part of my particular team but with whom I have contacted to learn about their experiences or to ask for their expert advice. Once they have given their advice they step down from the train and I continue on my journey.

Over the years, I have discussed this journey with many people but at the very beginning of this journey, I was introduced to three important people (my supervisory team) who helped me arrive at my destination and who helped me overcome the stops and starts that one encounters on any journey. The consistent support I have received from this team has helped me reach this goal and their continuous support has encouraged me to complete my journey.

Through this journey with stakeholders, I have realised how older adults struggle to keep living safely and independently in their own homes. This reminded me that during the journey, I did encounter difficulties, sad moments and failure but there was also achievement, moments of joy and success throughout the whole process. As with the older patient's journey, I realised that the path to success is not always straight. Obstacles have to be overcome.

I have always believed that when there is a will there is a way. I am convinced that the work conducted in this study has made a real difference in the lives of older fractured femur patients. The countless hours and endless effort to enhance practice by all the stakeholders will continue to flourish for the benefit of the patient.

I would like to conclude with Mahatma Gandhi's wise words, who stated that "*the best way to find yourself is to lose yourself in the service of others.*"

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