UNIVERSITY OF SOUTHAMPTON

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An Evaluation of Intermediate Care in the Community

by

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ABSTRACT

This study is a result of one not-for-profit organization's aim to develop and evaluate a new approach to intermediate care (IC) by drawing together three separate enterprises; a not-for-profit charitable organization, a primary health care trust and local referring hospitals and social care providers in order to design a new service. This research describes and examines the factors that influenced the success (or not) of this IC service during its first two years of functioning.

Using a single descriptive case study a detailed account of the innovation journey that a multidisciplinary team (MDT) underwent as they developed and implemented their own unique model of person-centred intermediate care (PCIC) within a community based nursing home facility is provided. The study describes the workings of the unit and details the service users' outcomes and their perceptions of the care that they received on this unit.

Through the use of a mixed methods, concurrent triangulation, design quantitative data (i.e. assessments of functional ability and length of stay (n= 94)) and qualitative data (i.e. semi-structured interviews-staff (n=12), service users (n=94)) were collected in order to generate thick description which allowed for an in-depth explanation of how a new event (PCIC in a nursing home) was integrated into the culture of the facility. This design allowed the data, once analysed, to be discussed from different viewpoints in order to simultaneously address the confirmatory and exploratory aims of the study. The results of this research provide the field of IC and the practice community with a detailed account of the successes and challenges that one MDT's experiences during their innovation journey whilst crafting and successfully implementing PCIC within a community based nursing home facility. This study also exposed the staff's use of emotional labour in order to successfully deliver their model of PCIC.

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DECLARATION OF AUTHORSHIP

I, Heather Fillmore Elbourne declare that the thesis entitled “An Evaluation of Intermediate Care in the Community” and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission

Signed: ………………………………………………………………………..

Date:………………………………………………………………………….

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With the oversight of my main supervisor, editorial advice has been sought. No changes of intellectual content were made as a result of this advice.

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Abbreviations

AC	The Audit Commission
BSC	Balanced Scorecard
CBNHIC	Community based nursing home intermediate care
CSCI	Commission for Social Care Inspection
DH	Department of Health
IC	Intermediate care
JON	**The** intermediate care unit
THE JON FOUNDATION	**The** organization responsible for JON
NHS	National Health Service
NSF	National Service Framework for Older People
NHIC	Nursing home intermediate care
PCIC	Person-centred intermediate care
SU	Service users

CHAPTER 1

INTRODUCTION

1.1 Introduction to the chapter

The following chapter begins the thesis by summarising the context of the research and highlighting the rationale for undertaking a mixed method, case study approach, to exploring and describing the innovative journey of one particular nursing home based intermediate care facility. The journey occurred during their first two years of providing, person-centred intermediate care to a segment of the UK's ageing population. The chapter provides a succinct introduction to the research and presents a detailed description of the study's research question, its aims and objectives, and concludes by describing the organization of the thesis.

1.2. The context of the research

On or about October 1, 2006, an agreement was made between the University of Southampton's then School of Nursing and Midwifery and the JON Foundation, whereby the JON Foundation made a grant to fund a research project that would entail an investigation and evaluation of its intermediate care unit at JON. The JON Foundation specified that this project was being funded in order to advance public knowledge in the care of older people and, in particular, to:

1. establish best practice in the care of older people;
2. support the education of a research student;

3. create intellectual property for the benefit of the research and education establishment.

By virtue of the contractual agreement entered into by these two parties, it was established that the research project would focus specifically on JON alone – as a case study – and would commence on October 1, 2006 and continue for a period of three years at a minimum. To avoid any doubt, the JON Foundation made clear that the appointed research student would not be an employee of the JON Foundation during the research. However, I would have the freedom to determine the type of case study approach used and the methods for data collection and analysis adopted.

1.3. The wider context of the research

In Britain, the growing need to provide community based support as an alternative to acute hospital admissions dates back to winter bed initiatives in the 1990s (Audit Commission, 1992; DH, 1997). Decades of financial overspending and the resultant inherited economic pressures, coupled with a looming crisis due to the forecasted unprecedented number of ageing people in the UK, left the National Health Service (NHS) in a quandary. As a result, in 2000, the NHS introduced a radical ten year plan to modernize its health and social services (DH, 2000b). Intermediate care was a key element of this plan which focused on reducing public expenditures, relocating resources and providing an alternative to acute hospital admission for the ageing population. Endorsed as an important approach to promoting the independence of older people, whilst concurrently relieving pressure on the acute care sector, the NHS Plan committed considerable financial resources (£900 million by 2004) in support of intermediate care (DH, 2000b). Conversely, the Government offered very little guidance in defining and providing operational direction for this new level of care.

This approach to employing a new level of service within the NHS ultimately resulted in a service being implemented throughout the UK, without a robust supporting evidence base. To encourage ‘country-wide’ implementation the Department of Health sent out a circular (DH, 2001a) and set out a framework (DH, 2001) that attempted to clarify the broad characteristics of intermediate care. These directives were set against a plethora of analogous definitions for intermediate care services (Steiner, 1997; Stevenson & Spencer, 2002) as well as various reports and guides which were produced to promote good practice and quality improvement within intermediate care services (Steiner, 1997; Vaughan & Lathlean, 1999; Stevenson & Spencer, 2002).

Since the implementation of intermediate care various research initiatives have focused on evaluating specific aspects of intermediate care (Godfrey et al., 2005; Barton et al., 2006; Young et al., 2007; Griffiths et al., 2009). However, there was, and still remains to this day, a piecemeal approach to defining, conceptualizing and evaluating this service. This has been compounded by the lack of an accepted comprehensive model of care with which to replicate further IC practice and research (Enderby & Stevenson, 2000; Stevenson & Spencer, 2002). Furthermore, although the last decade saw a great deal of research focusing on the implementation of intermediate care within Nurse Led Units there exists a paucity of research focusing on community based intermediate care and in particular, and of interest to this study, a lack of research on intermediate care delivered within a nursing home facility. This study endeavours to fill this gap by providing a detailed account of the innovation journey that a multidisciplinary team underwent as they developed and implemented their own model of person-centred intermediate care within a nursing home facility. The study describes not only the workings of the unit but also details the service users' outcomes and their perceptions of the care that they received on this unit.

This study is a result of one not-for-profit organization's aim to develop and evaluate a new approach to intermediate care by drawing together under one roof three separate enterprises – the work of a not-for-profit charitable organization, the work of the primary health care trust and the local referring hospitals and the work of social care providers – to provide a person-centred approach to intermediate care within their nursing home setting. The organization responsible for this unit (referred to as the JON Foundation) is a not-for-profit, registered charity, dedicated to providing alternative configurations of services in order to improve the quality of life for older people as it strives to influence the future direction of healthcare for older people within the UK. The JON Foundation's latest venture was a purpose built care facility (referred to as JON) within which they had developed an innovative model of care, which aspired to set new standards for community based, nursing home intermediate care in the sector. Driven by a commitment to providing and enhancing quality care, and a belief that an innovative approach was vital to care, JON's model focused on intermediate care delivered through a partnership between the not-for-profit sector and health and social care service providers.

At this juncture, it is important to note that this study does not affirm that JON is the only not-for-profit organization which has ever partnered with the health and social care sectors in order to provide care, be it intermediate care or not. Rather when referring to JON's 'unique' model of person-centred intermediate care the study is reiterating the words the CEO of the JON foundation used to describe JON's partnership between themselves and the health and social care sectors in order to develop and implement person-centred intermediate care within their nursing home setting. The partnership and the resulting model of care was 'unique' to JON and the staff that underwent an innovation journey whilst crafting and implementing their own particular model of care. This is supported by Van de Ven et al. (1999) who states that as long as the innovation is viewed as new or 'unique' to the people involved, it can be considered an 'innovative idea'; even if there are other very similar 'ideas' that exist elsewhere (p. 9). This study focused specifically on JON's new 20-bed intermediate care unit. Even though this unit was a registered nursing home, it was not a permanent home for older people. The purpose of the unit was to provide episodes of care in the form of rehabilitation for early discharge from hospital (step down care) and an alternative to hospital admission (step up care) for older people living in the community (including the residents of JON's independent living accommodations which share the same geographical location).

A single descriptive case study (Yin, 2003a) was used to investigate this contemporary phenomenon within its real-life context; this describes and examines the factors that influenced the success (or not) of the community based, nursing home's intermediate care unit during its first two years of functioning. Within the case study, a mixed methods concurrent triangulation design was implemented to capture the best of both qualitative and quantitative data collection and analysis approaches. This ultimately allowed the data to be discussed from different viewpoints in order to simultaneously address the confirmatory and exploratory aims of the study (Tashakkori & Teddlie, 2003). Closed-ended quantitative data and open-ended qualitative data were collected in order to best understand the particularity and complexity of this single case (Creswell, 2003).

The study utilised qualitative methods of in-depth data collection and incorporated structured and semi-structured interviews with staff, informants and service users in order to generate what Geertz (1973) refers to as 'thick description'. A thick description is one that explains both a behaviour/event/process and its context such that the behaviour/event/process becomes meaningful to an outsider. The use of thick description supported the study's objectives, specifically explaining how a new event (i.e. person-centred intermediate care in a nursing home) was understood and integrated into the culture of the facility. In other words, how a facility and the teams within that facility, along with the individuals involved, implemented and made sense of the new practice.

1.4. Aims and objectives of the research

This case study aimed to:

1. Describe the work of a community based nursing home intermediate care unit during its first two years of functioning.
2. Evaluate the effectiveness of JON's model of care used on the unit using the JON Foundation's own predetermined success criteria. More specifically, the research objectives are to:
    a. Provide thick description of the workings of an intermediate care model used within one community based nursing home facility. This entailed detailing the model of care, how and why the model worked (or not), and providing sufficient detail for replication of the model elsewhere if it was evaluated positively in the second element of the study.

    b. Determine and comment on the impact and effectiveness of the intermediate care model that was used at JON in relation to the achievement of the organization's original predetermined success criteria, based on the following categories:

        - service user satisfaction (satisfaction with amount of recovery and care received);
        - care outcomes (destination at discharge, increase in functional ability);
        - process (model of operation being used, e.g. person-centred approach to care; rehabilitation approach focus; admission/referral sources; length of stay);
        - value for money (from a service users perspective, not a financial account, e.g. did the service user functionally improve and were they discharged home?);

3. Provide feedback of the findings locally to key stakeholders (funders, key service participants) and staff/informants at specific points during the study (i.e. at four-monthly intervals) to ensure the early communications of the findings and provide an opportunity for the re-shaping of care in order to maintain the best interests of the service users as the study progressed. Disseminate the findings widely at a national level, from an early stage of the project through standard publication and seminars.

1.5. Organization of the thesis

The thesis comprises a further six chapters which have been presented in a style that reflects the chosen research approach. They are as follows:

Chapter 2 provides the theoretical context for the study. It details the process undertaken to obtain the primary literature that is presented in order to contextualise intermediate care and JON at the outset of the study. The chapter substantiates the rationale for the current study and concludes by detailing the research questions.

Chapter 3 describes the research approach by detailing the study's design. In this chapter, the philosophical underpinnings of this study are also explored.

Chapter 4 uses Van de Ven et al.'s (1999) innovation journey model as an organizing framework in which to present JON's innovation journey. Using thick description the chapter details the working of the unit and the innovative nature of JON's model of care. This chapter also explains the challenges JON's MDT faced as a group in relation to the literature on normal group development and uses the themes and narratives generated from staff interviews to explain chronologically how JON's innovation journey progressed.

Chapter 5 provides a detailed account of the services users' qualitative and quantitative data in order to measure the progress of this innovation based on the founding organization's key indicators for success.

Chapter 6 presents the results from triangulating the two data sets, an in-depth discussion on emotional labour, and the challenges of implementing person-centred intermediate care.

Chapter 7 re-immerses the study's data in the contemporary literature and discusses the strengths and weaknesses of the study as well as its contribution to knowledge. The chapter also includes a reflection on the study's design and highlights the implications of the findings for future practice and research.

CHAPTER 2

LITERATURE AND BACKGROUND

2.1. Introduction to the chapter

This chapter contextualises intermediate care by presenting the literature which focuses on the development of this service within the NHS. It also details the development of one community based nursing home intermediate care facility as it crafted and implemented its own model of care for older people. Although this study focuses on a nursing home intermediate care facility (NHIC) the majority of the literature presented in this chapter and throughout the thesis focuses on intermediate care in general. This is because, at the time of the study, there was a paucity of literature specifically focusing on intermediate care within the nursing home sector.

In undertaking the task of elucidating this new service[1], or level of care, it was imperative to delve into the history of its development. The chapter begins by detailing the literature search process that was undertaken in order to uncover the information which forms the basis for the detailed account of the origin of intermediate care that follows. The driving forces of this new service as well as the supporting policies and strategy documents that are relevant to the origin of intermediate care are presented. The latter part of the chapter describes one community based, purpose built care facility (referred to as JON) that aspired to set new standards for nursing home based person-centred intermediate care in the independent not-for-profit sector, and their innovative model of intermediate care, which is based on the amalgamation of the National Service Framework for Older

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[1] Throughout the literature and during staff, informants and service users interviews intermediate care was referred to as a service e.g. the intermediate care service being provided on the unit and also as a new level of care e.g. this level of care has provided rehabilitation for my mother.

People's (DH 2001) Standard Two: Person-centred care and Standard Three: Intermediate care.

2.2. Literature searching process

The literature review is broken down into two components: the primary literature review and the secondary literature review. The primary literature review, which is presented in this chapter, was conducted in order to engage with the subject area. This study resulted from one organization's (the JON foundation) desire to document the journey their team underwent whilst taking an innovative approach to implementing intermediate care in a nursing home setting. The primary literature review was instrumental in refining the research question whilst simultaneously adding a unique contribution to knowledge. Specifically, by acquiring knowledge of intermediate care, such as details of the service, from its development to examples of intermediate care units, how it had been researched and what the key issues were, gaps in the knowledge were exposed. This information or rather the lack thereof (on how to best implement IC within a nursing home setting) was synthesized with the JON foundation's query (how is our model of IC doing?). This resulted in a research question (see section 2.4.) that addressed JON's need to evaluate their model of care, whilst concurrently filling a gap in the current knowledge base by providing the larger health care community with an example of one community based nursing home intermediate care model in practice and ultimately, developing the knowledge base on intermediate care for all involved. The organization responsible for this study was largely responsible for dictating the case study approach to the research whereas the primary literature review process assisted in refining the research question whilst developing the rationale for this study's approach (mixed methods, see section 3.5.), the methods chosen (see section 3.7. & 3.8.) and the theoretical position assumed throughout the study (see section 3.3.).

The secondary literature review was done in response to the study's findings, and consequently incorporated into the discussion chapter of this thesis (see chapter 6 & 7). This manner of reviewing the literature allowed for an unbiased approach to data collection and analysis by permitting themes to emerge naturally from the data collected and to be further explored theoretically, once all the data were collected and analysed. The literature search process for both the primary and secondary literature was iterative and complete, when no new records or retrieval of information occurred. The focused and consistent approach that was employed during this process can be found in Appendix 1.

2.3. Primary literature review

The first part of this primary literature review focuses on our ageing population, which in turn focuses on those adults 60+ years old. Although JON's intermediate care unit was open to people as young as 55, this was only on merit and not a true representation of the unit's population whose service users were predominantly in their 80s (personal communication, CEO, 2007). Furthermore, intermediate care is a service dedicated to caring for the UK's 'older population' (DH 2001) and according to the United Nations Population Division this category refers to those 60 years or older. Therefore, this discussion focuses on those over 60 years of age (UN, 2009).

The global population is ageing at an unprecedented rate. In 2009, the United Nations Population Division estimated that there were 737 million people who fall under the 'older population' category (referring to those 60 years or older). As the 21st century began the world population included approximately 600 million older people, triple the number recorded fifty years earlier. By mid-century, the ageing population will grow to an estimated two billion, yet again a tripling of this age group in a span of fifty years (UN, 2009). Today, one out of nine persons is aged 60 or older and it is estimated that by 2050 this ratio will increase to one out of every five (UN, 2009).

The older population is, itself, ageing. In fact, the fastest growing age group in the world is the oldest-old, those aged 80 years or older (Kinsella & Velkoff 2001). By 2050, 20% of the world's older population (60+) will be aged 80 years or older (UN, 2009). In England an estimated fifth of the population is now over 60; and it is forecast that in the years 1995-2025 the group of adults aged 80+ will increase by almost half and the group of adults aged 90+ will double (DH, 2001).

These changing demographics have the potential to adversely affect our work force as well as many other aspects of our current society. It is predicted that this historically unparalleled rate of growth in older people will be accompanied by:

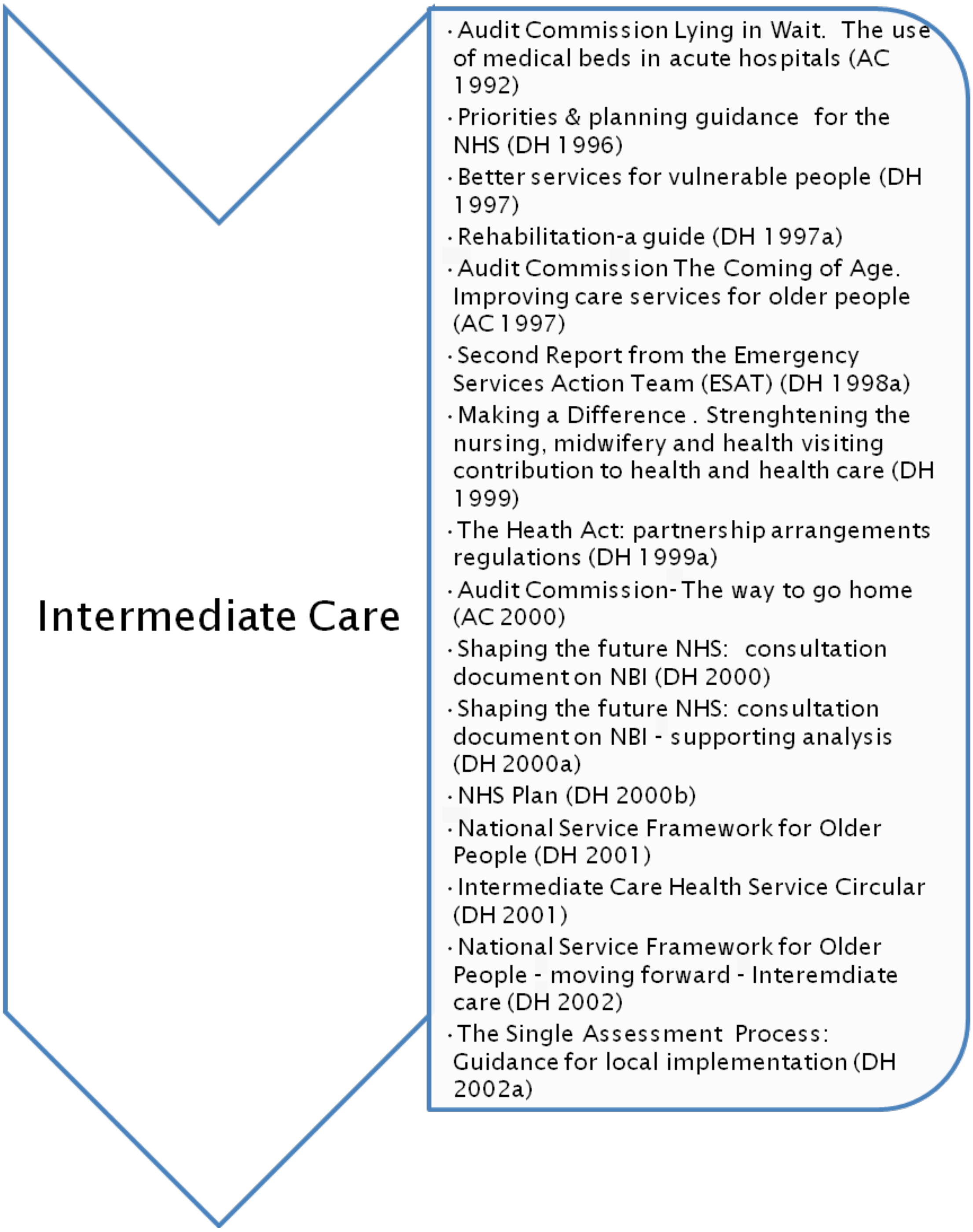
1. reductions in the proportion of children;

2. decline in the proportion of persons of working age (15 to 59).

This decline in growth of the number of children and potential workers to care for older people is expected to have a profound effect on our current health and social care structures, as the health of older people typically deteriorates with increasing age and thus induces greater demand for long term care (UN, 200). The potential increase in demand for care, coupled with fewer workers, will have a direct effect on the way we view our current society, specifically our health and healthcare, family composition, living arrangements and housing, and migration (UN, 2007).

The NHS, recognizing that changing demographics present important social and economic differences that have a direct bearing on social and health policies now and in the future, proactively set forth various changes to its health and social care systems. The NHS addressed one aspect of this multifaceted social phenomenon by developing 'intermediate care'. The NHS's major strategic decision, to develop a new model of service delivery, has become a core element in the Government's agenda on improving services for older people (DH, 2000b, 2002; DH, 2000). Introduced into England's health care culture in 2000, intermediate care has made substantial progress in becoming a recognised mainstream service. Figure 2.1 presents the Department of Health's and the Audit Commission's supporting documents, reports and health circulars that were instrumental in the development of this service.

Figure 2.1 Important policy and strategy documents



- Audit Commission Lying in Wait. The use of medical beds in acute hospitals (AC 1992)
- Priorities & planning guidance for the NHS (DH 1996)
- Better services for vulnerable people (DH 1997)
- Rehabilitation-a guide (DH 1997a)
- Audit Commission The Coming of Age. Improving care services for older people (AC 1997)
- Second Report from the Emergency Services Action Team (ESAT) (DH 1998a)
- Making a Difference . Strenghtening the nursing, midwifery and health visiting contribution to health and health care (DH 1999)
- The Heath Act: partnership arrangements regulations (DH 1999a)
- Audit Commission- The way to go home (AC 2000)
- Shaping the future NHS: consultation document on NBI (DH 2000)
- Shaping the future NHS: consultation document on NBI - supporting analysis (DH 2000a)
- NHS Plan (DH 2000b)
- National Service Framework for Older People (DH 2001)
- Intermediate Care Health Service Circular (DH 2001)
- National Service Framework for Older People - moving forward - Interemdiate care (DH 2002)
- The Single Assessment Process: Guidance for local implementation (DH 2002a)

The following section of this review focuses on these documents, as well as other pertinent publications that underscored the development of intermediate care, and on why at the time of its inception it was being heralded by the NHS as a means of resolving their then bed crisis and and the existing and potential issues posed by the UK's ageing population.

2.3.1. Driving factors in the development of intermediate care

By the turn of the century, there was growing unrest surrounding the NHS in regards to the care of older people. Several key predicaments came together to expedite the need for a new service and to launch the concept of intermediate care. These factors or drivers to the development of this service are listed below, followed by an in-depth discussion on each:

- increasing pressures on the acute bed sector;
- inappropriate placement of older people in long term care;
- the decline in NHS rehabilitation services;
- the working together of the health and social care sectors;
- the need for a seamless continuum of care.

2.3.1.1. Increasing pressures on the acute bed sector

In England during the twenty year period from 1977–1997, the availability of acute and geriatric beds fell on average 2.0 %, whilst admission rates had risen by 3.5 % (DH, 2000). As early as 1992, The London Audit Commission produced a report highlighting the inappropriate use of acute, dedicated hospital beds, specifically by older people, whilst describing the complex needs of this age group, particularly in the area of rehabilitation (AC, 1992). In their King's Fund publication, Vaughan and Lathlean (1999) called further attention to the increasing pressure on the acute sector beds, asserting that winter pressures, new and advanced technical and pharmaceutical advancements and increased medical admissions were resulting in a timely need for a more sophisticated, post-hospital care scheme. Furthermore, they noted that although hospital length of stay was getting shorter, admissions were increasing.

Compounding this was the fact that acute and geriatric beds were decreasing in numbers.

Hospital re-admissions were not a new concern; in fact in 1988, Townsend et al. (1988) noted that patients over the age of 75 represented over 40 % of the hospital bed users in the UK, with over half of hospitalized older people (75+) being re-admitted within eighteen months of discharge. These grim statistics did not recover over the next decade, but they did cause the Government to respond.

The Government was concerned that the long term decline in hospital beds had gone too far. The staffed hospital bed numbers and types would not meet the needs of patients in the next 10–20 years. Thus, they commissioned a study on bed occupancy, now known as The National Beds Inquiry. The findings of this National Beds Inquiry also demonstrated overwhelming support for care closer to home. It stressed the significantly inappropriate or avoidable use of acute hospital beds. The inquiry reported that people aged 65+ occupied two thirds of general and acute hospitals' beds, and accounted for over half of the recent growth in emergency admissions. A literature review prepared by this inquiry suggested that for older people, an estimated 20% of bed days were inappropriate if alternative facilities were available (DH, 2000).

In 2000, the DH responded to the findings of this inquiry and published a consultation document and supporting analysis (DH, 2000, 2000a). In support of IC, a noteworthy portion of this consultation spoke to the continued 'hospital re-admissions' crisis. The document emphasized the need to have functioning post-acute options accessible in order to ward off further increases in re-admission rates. It warned that if this trend was allowed to progress unabated, the country would experience 'a considerable rise at considerable expense' to the healthcare system which would ultimately be to the detriment of patients. With occupancy levels running at nearly 100%, it was widely agreed that the NHS up until this point was functioning under this pressure, but the pressure was starting to take its toll (DH, 1997, 1998, 2000, 2000a; AC, 1997).

2.3.1.2. Inappropriate placement of older people in long term care

Although many patients, particularly older people, would prefer to be at or close to home whenever possible this preference can and has been overlooked in the past. Pressure to deal with social admissions (i.e. patients admitted to hospital for non-medical reasons such as failure to cope at home) and delayed discharges (i.e. patients who are medically stable, yet linger in a hospital bed until care can be organised at home or elsewhere) has resulted in in-patients being channelled into existing services (i.e. residential care) (DH, 1998a). Published in 1998, The Emergency Services Action Team (ESAT) report expressed concern over the inappropriate placement of in-patients into long term care facilities and furthermore noted that, on average, 70% of those over 75 years of age in long term care stay for 2.5 years. Although the number of people dying within weeks of admission to nursing homes was on the increase, so too were the numbers staying 6-8 years. The report raised concerns over whether or not older people's needs were being holistically met. It questioned if older people were being prematurely placed in long term care, when an alternative short term rehabilitation stay would prove to be beneficial in helping them regain their pre-hospital or pre-crisis levels of functioning, which would then allow them to return home.

Older people who experience an acute care crisis can quickly undergo complex changes in their dependency level. That being said, following this medical crisis, their dependency levels may return to functional levels within a two to three week period, as their ability to function independently begins to rise (Redfern 2006). However, it was noted that at the time, within the NHS, the ability to routinely undertake a second and later assessment did not exist and, as a result, older people were being prematurely placed into long term care. As such, the report recommended the Government invest in intermediate care/ rehabilitation schemes that could equip patients to return home (DH, 1998). Concurrently, the Audit Commission Report also stressed the existence of too few investments in prevention and rehabilitation services and concluded that this lack of investment was resulting in unplanned hospital admissions for older people and premature admissions to long term care facilities (AC, 1997).

2.3.1.3. The decline in NHS rehabilitation services

By 2000, expectations of intermediate care were now growing broader. The Audit Commission (2000) established an unequivocal link between rehabilitation and IC, and emphasised the need for rehabilitation to be an integral part of the IC service. However, at the time, throughout the country not only was there a shortfall of rehabilitation provision within the NHS, but the decline in services over the last two decades had resulted in a likely shortage of qualified staff who were familiar with transitional care models and how to implement intermediate care rehabilitation. In 1998, both Robinson and Turnock (1998) and Nocon and Baldwin (1998) provided evidence of these shortcomings in the health and social sectors with regards to rehabilitation. Nocon and Baldwin (1998) in particular emphasised the lack of seamless provision of rehabilitation services to the elderly, pointing out the importance of rehabilitation not only in assisting in the pressure to reduce the length of stay (LOS) in acute care beds, but also in reducing unnecessary admissions to long term care facilities. Both publications offered suggestions of good practices and processes that would be beneficial in recovering these services. In particular, Nocon and Baldwin (1998) offered ‘four requirements’ that were needed in order to develop rehabilitation services that reflect good practice. They are as follows:

1. It was essential to have an explicit understanding of the objectives of rehabilitation and organize effectively in line with these objectives;
2. Financial incentives were needed if improved rehabilitative opportunities were to be developed;
3. Rehabilitation practice and contracting needed to be evidence-based;
4. The evidence base must be further developed and improved, placing particular emphasis on the experiences of users and the outcomes (p. 22).

In the late 1990s, the NHS was seen to be making rehabilitation for older people a government priority. Using the concept of independence for older people through ‘timely’ recuperation and rehabilitation options, the NHS was seeking an end to a culture that fostered dependency in older people and identified rehabilitation as a means to this end (DH, 1997). Sinclair and Dickinson (1998) further emphasized the need for the use of rehabilitation approaches in different settings and called for a service without walls. However, the execution of this level of service and its focus on rehabilitation was not collectively implemented throughout all regions in the country.

Although introduced as a formal service at the turn of the century, two years into its running Stevenson and Spencer (2002) noted that, throughout the country, there was a piecemeal approach to the implementation of this service. Around the same time Wiles et al. (2003) pointed out that simply establishing a unit on which to provide intermediate care was not sufficient to ensure patients received rehabilitation. This study found virtually no difference in the mean quality of care between the nursing care being implemented on an acute care ward and the nursing care being given on a NLU, whose model of care emphasised (theoretically) rehabilitation, education and psychological support for patients' transitioning out of acute care. The authors stressed that in order to deliver high quality care, it was essential that staff have the necessary skills to provide the care needed and a proper model of care implemented.

From the inception of this service, there has been a lack of continuity in the implementation of intermediate care services throughout the country. The above findings highlight this, specifically in regards to IC's rehabilitation focus. The lack of a nationally accepted model of care surrounding IC has resulted in various communities moulding their own unique model of intermediate care around the needs of their residents. This individual approach to model development may well best meet the varied needs of individual communities. However, it does not provide a clear understanding of what services are being offered for older people throughout the country. Further research into intermediate care is needed in order to ascertain who is doing what and where throughout the UK in order to ensure similar services for older people are being implemented nationally. This study addresses this need by detailing the model of care being delivered in one particular community based nursing home facility.

2.3.1.4. The working together of health and social care sectors

The delivery of intermediate care services is dependent not only on a partnership between the NHS Trusts and the local authorities, but also on other working relationships such as the private sector, voluntary agencies, and health and social care

(Griffiths et al., 2002; Andrews et al., 2004). Fundamental to the NHS Plan was the development of innovative ways of working, which would overcome antiquated institutional barriers to the formation of these working relationships (HTA 2004). The Government stressed the need for a 'whole system approach', which would see health and social care agencies combining their scarce resources in order to work in partnership to provide efficient care for patients.

Interagency collaborative practice was being ascribed with the ability to not only recognize professional abilities and create avenues for the broadening of professionals' scope of practice but also minimize confusion for patients by providing a 'seamless' transition of care for those having to navigate through various agencies and levels of care (DH, 1996, 1997; Steiner, 1997). The Second Report from ESAT (DH, 1998a) further spoke of the 'inter-relationship' that needed to exist between health and social care providers, and drew attention to the ever-increasing need to have the Health Authorities, NHS trusts, primary and social care providers working together in developing planned approaches to care. It was widely believed that both sectors would need to be working together harmoniously if the NHS was to provide the right service, to the right person, at the right time, in the right location, in order, ultimately, to minimize confusion for service users (Steiner, 1997).

There exists a long history of disappointing attempts to promote and sustain collaborative practice environments between health and social care professionals (DHSS, 1973; Loxley, 1997; Lymberry, 1998; Goodwin, 2001). However, later government policy directives endorsed collaborative working relationships by removing some of the structural barriers, which had been cited as problematic when attempting to merge these two agencies (DH, 1996, 1999a; Hudson et al., 1999; Glendinning & Rummery, 2003; Dowling et al., 2004). Of particular note was the introduction of the following 'flexibilities':

- pooling of budgets for specified services;
- commissioning responsibilities to be delegated to a single head/lead organization;
- health and social care providers to be integrated within one provider organization (DH, 1999).

Furthermore in 2001, the Health and Social Care Act allowed the Secretary of State to induce the use of the new partnership flexibilities between social and health services organizations in situations where collaboration was judged to be inadequate

(Glendinning & Rummery, 2003; Hudson, 2006). It was acknowledged that the introduction of new ways of practising would assist in overcoming some of the structural constraints between the two agencies. However, there was no mention of how the cultural differences that existed between these two groups of professionals would be addressed. Loxley (1997) argues that it is not simply the knowledge, skills and processes required that makes collaborative practice difficult; it is the trust to work with and hand over responsibility to others that can be a stumbling block in inter-professional collaborative relationships. Finally, in regards to the private/voluntary sector, there is a lack of information on the roles and responsibilities of this sector and how they can integrate with health and social care in order to assist in providing a collaborative approach to intermediate care (Redfern, 2006; HTA, 2004).

2.3.1.5. A seamless continuum of care

There was growing interest in a service which would be seen as a 'seamless' (Shortell, 1994; Steiner, 1997) continuum of care that would support service users through their transition between acute, primary and social care. A great deal of debate ensued over where the most effective and appropriate care could be provided for older people after an acute illness. At the time, the term 'intermediate care' was being used for any sub-acute service that fell somewhere between primary care and chronic care (Stevenson & Spencer, 2002). In fact there existed a daunting array of services functioning between hospital and home already, and what was being proposed bordered on, or overlapped with, a range of existing options (see table 2.1). That being said there was no distinct coherent service category which would fulfill a transitional care function. The need existed for a locally-based service that bridged primary and secondary care, the goal being local, not primarily medical, but moving away from medical towards functional and/or convalescent goals, and allowing for a staging ground to sort out subsequent alternatives to care if need be (e.g. change in residential status).

Table 2.1 Intermediate Care: Between Hospital and Home

Service	Description of service
Community hospital	A unit that functions either as part of an acute Trust or as a Local extension of primary care. Provides a range of different services, including rehabilitation convalescence, discharge planning, visiting consultant outpatient care, minor casualty services, direct access services and minor surgery.
Community care centre	A model of care based on the Lambeth Community Care Centre. Local community has direct access to a range of therapies and inpatient services which do not require major technical interventions or medical specialist management. Short stays are intended, selection criteria include pre-identified discharge plan and respite service also offered. Nurse-led: medical cover from GPs.
Cooperative care centre	An American model providing hotel type facilities where both patient and partner are admitted and the partner retains the principal caring role, backed up by health care workers. The goal is to reduce demands on health care professionals' time, provide a safe environment with immediate access to medical support and develop self-care skills for patient and partner.
Hotel beds/patient hotel	Unmonitored beds which pre- or post- acute patients can use. Primary UK application to date has been to provide convalescent care to patients with low intensity needs who lack home support.
Inpatient nursing beds	Similar to all of the above However, there is a clearly identified clinical objective: to improve quality of life and ability to live independently. Intensive therapeutic input from RNS & PAMs. Admission criteria include pre-identified discharge destination, rehabilitative potential and established need for nursing (rather than medical) care. May or may not include NLUs.
Supportive discharge schemes	A wide range of service packages beginning with early discharge planning, tends to include multidisciplinary needs assessment, home visits and possibly arrangements for supportive services.
Hospital at home	A specific form of supported discharge targeted to people who require some kind of technical intervention and who have sufficient home-based support to allow health professionals to train informal carers and ensure continuity of care.

(Adapted from Steiner, 1997, p. 12)

The NHS was in the middle of a historic transformation driven by the predicaments outlined in these documents and detailed above. These driving forces were prompting major changes in the structure, organization, financing and delivery of health care in a bid to help solve system pressures. The National Beds Inquiry emphasised the need for community based care facilities that would provide an alternative to hospital admission, at the same time as promoting functional independence for older people (DH, 2000, 2000a). The NHS Plan supported the notion of community based care, emphasizing that its resources were stretched to capacity and its ability to cope had been reached and highlighting the need to reduce inappropriate bed use by the elderly as key to solving the noted bed crisis that the nation found itself in (DH, 2000b). The development of intermediate care was being seen as the main way to end acute beds being occupied by patients who no longer had acute care needs. Further, it was a key tool in developing a closer working relationship between health and social care systems thus providing an overall improvement in care for older people (DH, 2000b).

2.3.2. The inception of intermediate care

Andrea Steiner was commissioned by the King’s Fund to report on intermediate care and in 1997 published her conceptual framework and literature review. This is one of the supporting reports that helped to inform the work of those developing the intermediate care health care policy as well as various service providers and commissioners, academics and research communities who were considering future evaluation strategies. Steiner (1997) developed one of the first working definitions of intermediate care when, at the time, intermediate care was not a universally accepted provision of the NHS. In fact, at the time of her publication there was no recognised organizational component of intermediate care in the existing health care delivery system. However by 2001, and following the release of the NHS Plan (DH 2000b) and the National Service Framework for Older People (DH 2001), intermediate care became a recognised mainstream service; the idea of intermediate care began to permeate public discourse, and the interest of the independent sector began to rise. A decade on, reports suggest that every health economy within the UK now has contracts for at least some form of intermediate care services (CAT, 2008).

Intermediate care is a service that aims to facilitate a move from medical dependence to functional independence, with the main emphasis being the promotion of independence through active recovery (HTA, 2004). The underpinning of this service is that older people will have access to a new range of services that promote their independence, by providing enhanced services from the NHS and local councils in order to: prevent unnecessary hospital admission provide effective rehabilitation services to enable early discharge from hospital, and prevent premature or unnecessary admission to long term residential care (DH, 2001). Taken together, provided under the umbrella of intermediate care, service is intended to be a seamless continuum linking health promotion, preventive services, primary care, community health services, social care, support of carers and acute hospital care. According to the NSF (DH 2001), intermediate care is a model of service delivery that has three key points in the pathway of care:

1. Responding to or averting a crisis
2. Active rehabilitation following an acute hospital stay
3. Where long term care is being considered (p. 44).

The above key points highlight the difficulties in defining intermediate care. Although it was said to be a new service that would respond to or avert a crisis, existing services such as acute care could equally respond to or avert a crisis by admitting a patient into hospital. Additionally point two states that active rehabilitation, following an acute care hospital stay, would be a key aspect to this service; however, it does not address the service users who were being admitted from the community as ‘step up’.

Although a nationally accepted definition of intermediate care was (and continues to be) laborious in its development, it was widely recognised that this level of care would be made up of a range of services. These services would assist in bridging the gap between medical dependence and functional independence, from hospital to home, from acute health care to social care, as well as services that would assist in diverting inappropriate hospital admissions and untimely admissions into long term care. Even though a specific working definition was lacking, what intermediate care is *not* was clearer. Vaughan and Lathlean (1999) stated that intermediate care differed from:

- convalescence – which allows time for people to heal but has no active therapeutic input;
- hotel beds – which bring people near services, but offers no therapy;
- long stay beds – where it is unlikely that there will be sufficient recovery for people to be regaining dependent living;
- movement of services – from one setting to another i.e. the shift in treatment of deep vein thrombosis from acute to primary care;

- another layer in the service – rather it is being developed in response to what has become known as the ‘black hole’, where no targeted services have been available to help the transition between acute, primary and social care (p. 5).

Although talk of a continuum of services that would assist in the transition between the various levels of health and social services has begun to permeate the NHS discourse, there remains a gap in evidence of how and what this exact model(s) should look like. Up until this point no one has offered a ‘blueprint’ for the development of an intermediate care model. However, beginning to surface are examples of various models of practice initiatives, which are all mainly dependent on the drive of individuals rather than wider strategic initiatives (Steiner, 1997; Vaughan & Lathlean, 1999).

Defining intermediate care has been difficult and sometimes dubious. Whilst some argue that defining a subject too tightly leads to model constraint and creativity is lost, others disagree, voicing the need for a clear definition and common understanding in order to evaluate the effectiveness/efficacy of intermediate care services (Vaughan & Lathlean, 1999; Melis et al., 2004). As interest in the subject of intermediate care has grown, so too has the working definition, resulting in intermediate care becoming a catch-all term that encompasses a wide range of diverse practices in a plethora of venues (Pencheon, 2002). One such venue will now be discussed.

2.3.3. A community based nursing home intermediate care facility

The lack of a nationally accepted intermediate care definition has led to an opportunity to develop individual definitions. Within the independent not-for-profit sector, the JON Foundation refers to its nursing home intermediate care centre as an ‘episodic care centre’. Historically, the term ‘episodic’ has referred to an acute happening, only occurring sometimes and not regularly (Oxford English Dictionary, 2007). Within the health care field, it has been used to describe episodes of unexpected illness, accidents or conditions that require immediate attention, some being severe and requiring immediate hospitalization (i.e. acute cardiac pain) and others do not necessarily require transfer to hospital (i.e. sprained ankle). The JON Foundation based its decision to operationally call its in-patient nursing home intermediate care unit an ‘episodic care centre’ on its belief that intermediate care was a relatively new service and the public may not be aware of its episodic quality. The Chief Executive Officer (CEO) of the JON Foundation coined the term ‘episodic care centre’ (personal communication, CEO, 2007) to draw a distinction between this facility’s intermediate care service, which focuses on an episode of rehabilitation, and the traditional services offered in long term nursing home facilities. Although named the ‘episodic care centre’, throughout the data collection phase it became evident that the staff, informants and service users referred to the episodic care centre as ‘the intermediate care unit’ and therefore, throughout the thesis it is referred to as such.

Established in 1984, the JON Foundation is a registered charity that aims to provide high quality services to meet the changing and individual needs of frail older people. In the autumn of 2006, with the support of the foundation, JON opened a new purpose built care complex which housed among other services an intermediate care facility. This complex offers a wide spectrum of care to older people, by providing a full range of care facilities available under one roof so older people ‘never have to move’ (personal communication, CEO, 2007). The care complex comprises thirty 2-bed apartments, seven 2-bed lodges and a 20-bed in-patient intermediate care unit. This intermediate care unit provides nursing care and care staffing resources for the independent residents living in the larger complex, as well as intermediate care and respite care for the twenty service users admitted into the intermediate care unit. Out of the twenty beds on this unit seventeen of them were primarily dedicated for intermediate care and were supported by two local Primary Care Trusts (PCT & PCT2) and the remaining three beds were reserved for private residents wishing to purchase the services of the centre as respite care. This ratio changed as the study progressed and will be discussed in chapter 4.

The primary focus of JON’s intermediate care unit is on rapid rehabilitation for older people in order that they might: 1) vacate hospital beds earlier than otherwise (step down); 2) avoid unnecessary hospitalization (step up); 3) receive intensive rehabilitation to enable their rapid return home. The service in the unit is delivered by a multidisciplinary team consisting of a specialist doctor (n=1), a senior house officer (SHO) (n=1), nurses (n=23), therapists (n=2), rehabilitation assistants (n=2), social workers (n=2) and volunteers (n=42). This study describes the innovation journey that part of this community based nursing home intermediate care unit underwent in its initiative to reconfigure services and offer a radical, innovative, flexible approach to care for older people requiring intermediate care.

The JON Foundation sought an innovative means to developing a facility that would provide a ground-breaking service through the integration between the JON Foundation, the two local PCT units and the local NHS acute hospital. The underpinnings of JON's intermediate care unit are the joint commissioning of a not-for-profit private organization and health and social service staff to form a person-centred intermediate care team, working within JON premises, with a commitment to multi-professional working and inter-professional learning. According to the CEO of the JON Foundation, the JON Foundation 'hand picked' individuals from different professional and employment backgrounds to merge into one team in an effort to develop and implement a new intermediate care model which adhered to person-centredness whilst encouraging a whole system approach to the provision of services for the older person. As such the JON's unique and distinctive multidisciplinary approach to providing a PCIC service within a registered nursing home make this unit's innovation journey worth studying (personal communication, CEO, 2007).

The JON foundation's person-centred philosophy focuses on the right of older people to:

- Live secure in the knowledge that, even in the event of illness, they will never have to be moved from the comfort of their friends or familiar surroundings;

- Enjoy life among kindred spirits in an atmosphere of sympathy and understanding;

- Be cared for by people who appreciate their need for privacy and will in all situations respect their dignity and freedom of choice (personal comunication, CEO, 2007).

The Foundation's self-imposed key indicators with which to measure the success of their new intermediate care venture are patient satisfaction, care outcome, value for money and user satisfaction (personal communication, CEO, 2007). As such, these key indicators played a fundamental role in this study when evaluating the unit (see section 3.7.2. for more detail).

Although JON developed its model of PCIC and the criteria for its success, within the literature there is a lack of guidance on how to develop and evaluate a nursing home based intermediate care model. Furthermore, there is no literature that focuses on how to implement person-centred intermediate care within a nursing home facility. According to the NSF (DH 2001) Standard Two: Person-centred care, older people need to be treated as individuals and receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries. Although intermediate care (which is Standard Three in the NSF document) is clearly a level of care/new service, which is directed towards caring for older people, there remains a fundamental lack of supporting literature surrounding the process of developing an intermediate care (model using a person-centred approach. Furthermore, how does such a model of care relate to patient outcomes? This study endeavours to fill this gap by providing thick description of the innovative model of PCIC being delivered at this nursing home.

From new practices arises a new culture, dependent on creative ways of working. The challenges of commissioning, managing and providing care that requires cross-professional, cross-sector/agency work should not be underestimated (Humphris, 2007). There exists a tendency to idealise one's own practice patterns by over-simplifying a complex process that occurs in any effort to coordinate care. Collaborative relationships are not inherent in professional practice and they are often misinterpreted. Within a policy culture of collaborative practice between public, private and voluntary alliances, little is known as to how the different services interpret their roles and responsibilities within intermediate care, and what this means to service users in regards to satisfaction and care outcomes (Redfern, 2006). If we are to recognise the full potential of intermediate care, we must look at professional and organizational issues that may arise when implementing a new service (Steiner, 2001). The praxis of intermediate care requires analysis focusing on the development of a new model, as well as the culture shock that can arise when converting theory into practice and an old model to a new one.

Although the delivery of services using an intermediate care style predates the Government's policy to modernise social and health care, intermediate care is still evolving since its formal inception. Many venues, including nurse-led units, community hospitals, hospitals at home and patient hospitals, have been functioning in an intermediate care manner for years, some of which, hospital based nurse-led units in particular, have been well-researched (McCormack, 2003; Steiner et al., 2001; Richardson et al., 2001; Griffiths et al., 2001; Wilson-Barnett et al., 2001; Walsh et al., 2005; Green et al., 2005; Griffiths et al., 2009). Yet, across the country, within community settings, there remains a sense of fragmentation, a lack of consistency and poor integration with other key services. We are lacking a consistent application of the principles of intermediate care and a concrete model that will achieve standards of good practice across disciplines and agencies within community settings and specifically within nursing home facilities (Wade, 2003; Andrews et al., 2004).

From the literature reviewed for this study, it is evident that gaps in knowledge have existed from the very inception of intermediate care as a new level of service. Only a decade old, the intermediate care literature base is in its infancy and is in need of depth and breadth. Of particular note and specific to this study, is the intermediate care literature focusing on facilities that are not NLU and are not hospital based step down units. A recent systematic review found no evidence addressing intermediate care in nursing homes or in community hospital beds (Ward, 2003; Griffiths et al., 2005). In addition, there is a shortage of supporting literature that identifies the roles of the not-for-profit private sector and how they contribute (or not) to the development and workings of intermediate care within the UK (HTA, 2004). Older people are the main consumers of health care; however, there are relatively few evaluative studies that focus on the most effective ways of providing care for them. Addressing this lack of empirical data is vital if we are to succeed in meeting the needs of our ageing population. If the nature of nursing and its impact on intermediate care as a service for older people is to be fully understood, we must investigate, in all areas of care (acute, community, nursing home), IC's structure (integration of health and social care providers), process (multi-professional, single assessment, person-centredness, shared documentation) and outcomes (increased independence, decreased hospital re-admissions) (Spilsbury & Meyer 2001).

2.4. Research question

This study endeavours to add to intermediate care's knowledge base by answering the following question:

> What does a community based nursing home intermediate care model that seeks to integrate health and social services, voluntary and public sectors look like and what are the key elements of its success?

To ensure all components of this question were addressed the following objectives were met:

The study:

1. Described the work of a community based nursing home intermediate care unit during its first two years of functioning.
2. Evaluated the effectiveness of JON's model of care used on the unit using the JON Foundation's own predetermined success criteria. More specifically, the research:
   a. Provided thick description of the workings of an intermediate care model used within one community based nursing home facility. This entailed detailing the model of care, how and why the model worked (or not), and providing sufficient detail for replication of the model elsewhere if it was evaluated positively in the second element of the study.

   b. Determined and commented on the impact and effectiveness of the intermediate care model that was used at JON in relation to the achievement of the organization's original predetermined success criteria, based on the following categories:

      - service user satisfaction (satisfaction with amount of recovery and care received);
      - care outcomes (destination at discharge, increase in functional ability);
      - process (model of operation being used, e.g. person-centred approach to care; rehabilitation approach focus; admission/referral sources; length of stay);
      - value for money (from a service users perspective, not a financial account, e.g. did the service user functionally improve and were they discharged home?).

2.5. Summary of the chapter

The population is ageing at an unprecedented rate. This change in demographic make-up has a number of implications; particular to this study is the reconfiguration of services to meet the health care needs of this population. At the start of the century the British government recognized this and set out a ten year plan for investment in and modernization of the NHS. One key element of this plan was the development of intermediate care as a recognized NHS service. Over the last decade intermediate care has evolved as a concept rather than a specific type of service. The clear lack of a model for intermediate care can be seen as a strength, as it lends itself to be applied to a wide range of circumstances, to suit the varied needs of the communities and individuals that support them. In many parts of the country, locally-led initiatives have been developed to address the need to promote faster recovery from illness, promote a more effective use of acute hospital beds, prevent unnecessary acute hospital admissions, support timely discharge and maximize independent living. However, this flexibility in the service model has also led to confusion and fragmentation. There exist a diminutive number of evaluations on the effectiveness of CBNHIC services as a whole and no evaluations on intermediate care from a nursing home perspective. Therefore, there is a notable shortage of representation to guide future investment decisions and the work of practitioners and carers as they attempt to interpret intermediate care to best meet their needs and the needs of the communities they serve.

This study endeavours to fill this gap by detailing one not-for-profit organization’s innovative approach to implementing intermediate care within a nursing home facility by working in partnership with health and social care providers. Specifically, the study portrays the innovation journey undertaken by one multidisciplinary team (that was made up of four different groups of professionals, employed by three different employers – not-for-profit, health and social care services), whilst adhering to nursing home regulations (CSCI, 2006) as well as their own individual professional bodies’ regulations, in order to develop and implement a PCIC model. Additionally, the study measures the success of this model through the service users’ perceptions of the care being implemented on this unit, and their care outcomes.

CHAPTER 3

THE RESEARCH APPROACH

3.1. Introduction to the chapter

This chapter provides a detailed description of the philosophical and methodological frameworks used within this mixed methods case study. In undertaking the task of elucidating the methods chosen, it is essential to also identify the theoretical underpinnings that supported the decisions made regarding the structure of the study. As such, the chapter provides a description of the study's design, accompanied by a philosophical discussion including the principles guiding the study as well as the rationale for selecting a mixed methods case study approach. Woven throughout the chapter are details of how the philosophical approach adopted gave structure and defined the steps, procedures and strategies that were used within this study to collect, analyse, interpret and present the data.

The chapter highlights for the reader how the underpinning philosophy and principles of the research were implemented at a practical level whilst being continually monitored throughout the lifespan of the study in order to ensure the methods chosen remained fit for purpose. At the same time, the chapter focuses on describing the methodological framework that supported this research. This includes an in-depth discussion of the study timelines, data collection, sampling strategies, data management and the ethical considerations that were considered throughout the study. The chapter concludes with an explanation of the dissemination strategies that took place during the study's time frame.

3.2. The research design

This study was informed by a constructivist worldview and involved the use of a single descriptive case study design (Yin, 2003a), using a mixed methods approach to data collection, management and analysis. To grasp the complexity of this single case, the study incorporated an in-depth blend of qualitative and quantitative data collection techniques in order to explore the constructions and the workings of the intermediate care service provided to older people in JON's intermediate care unit.

In this particular study, as set out by the funders, I was given the object to be studied. The boundaries of this case were outlined by the funders as being JON's intermediate care unit expressly, its model of intermediate care and thus the unit of analysis, or the case, was given. Following a review of the literature that surrounded intermediate care, particularly the gaps in knowledge, it was decided that employing a mixed methods approach to studying this case would enable the study's question to be answered whilst simultaneously addressing the research gaps. Employing a case study approach allowed me to choose this particular facility and come to know it well (Platt, 2007). A mixed methods approach afforded the study the opportunity to collect, analyse and describe the data in a way that would add to the current body of IC literature a rich description of how a nursing home facility developed and implemented a person-centred intermediate care model. Although a funded study, the research question drove the selection of the design and methods used within this case study.

Fundamental to any case study research design is specifying what the unit of analysis is (Yin, 2003). A case may be an individual or an event; and is always a specific, complex, functioning, bounded object to be studied. Specific boundaries are needed to help identify the relevant information that is to be collected about the case in order to a) set limits as to what needs to be studied and b) ensure the researcher stays within the limits of the study. For this case study the boundaries were as follows:

- the unit of analysis was the intermediate care service being provided in JON's intermediate care unit;

- within this unit, there existed a mixed sample of subunits;

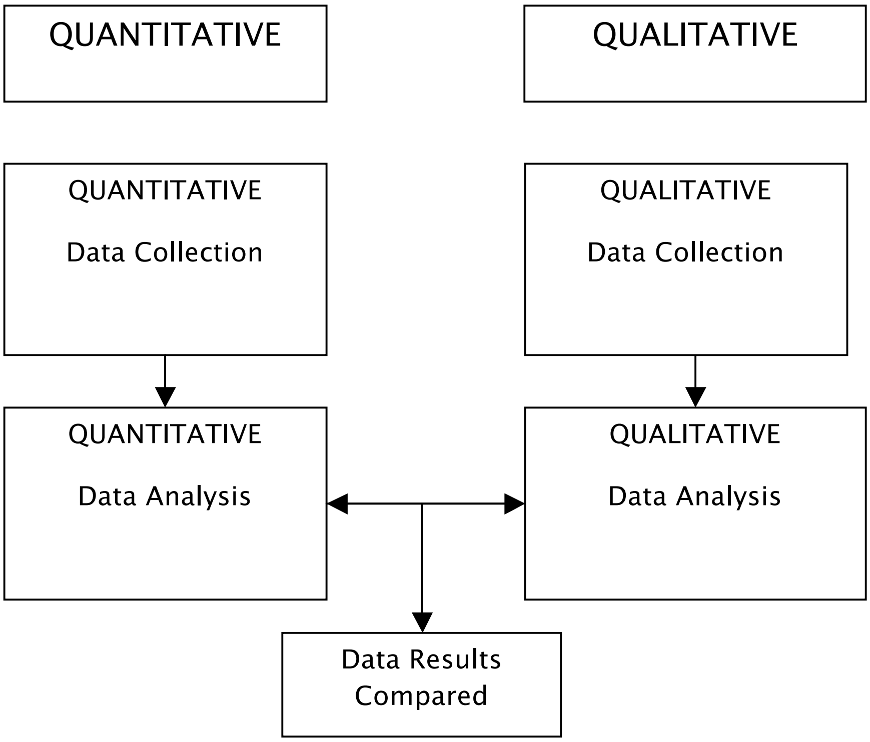
- these subunits were made up of informants who were from the JON Foundations managerial staff (see section 4.1.), staff with dedicated working hours on the IC unit (see section 3.7.1.1.1. for inclusion/exclusion criteria) and service users admitted to the unit who were expert witnesses to the care received whilst at JON (see section 3.7.1.2.1. for inclusion/exclusion criteria);

- data collection commenced August 1, 2007 and ended July 31, 2008.

See section 3.7 for further details.

In seeking to understand the uniqueness and complexity of this single case, data collection methods (see table 3.1) relied upon multiple sources of evidence (Yin, 2003a). The impact of this service was explored from the individual service user's perspective. The study gathered information to describe the model being used in the unit and investigate the impact of purposive cultural change on the health care team. A concurrent triangulation mixed methods design guided the data collection analysis and presentation of the findings within the study (see figure 3.1).

Figure 3.1 Concurrent triangulation design



Adapted from Creswell et al., 2003, p. 236

According to Creswell et al. (2003), the Concurrent Triangulation Design is probably the most familiar of the major mixed methods designs. This design is chosen when a researcher uses two different methods in an attempt to confirm, cross-validate or corroborate findings within a single study (Green et al., 1989; Tashakkori & Teddlie, 2003). A concurrent triangulation design is one in which qualitative and quantitative data collection is concurrent, and happening during one phase of the study (Creswell et al., 2003, p. 227). Data sets are analysed concurrently. The results from each separate analysis are triangulated in order to provide a richer picture of the case. Equal priority is placed on the collection and analysis of the qualitative and quantitative data thereby emphasising the importance of both to the formation of a rich picture of the unit of analysis. Whilst implementing a concurrent triangulation design this study's quantitative and qualitative evidence were gathered from:

- unstructured interviews with informants, semi-structured interviews with staff and service users;
- service users' satisfaction questionnaires;
- service users' Barthel index 100 scores on admission & at the time of discharge;
- document analysis (e.g. annual reports);
- analysis of routinely collected activity data regarding admission patterns and resource use.

The findings from the staff qualitative data are located in chapter 4 in order to provide a chronological account of the innovation journey JON underwent whilst implementing their model of care. The quantitative data and the qualitative findings from the service users' interviews are located in chapter 5 in order to measure the progress of JON's model of care from the service users' perspective. Finally, the triangulated results are discussed in chapter 6.

3.3. The philosophical underpinnings of the research

This study was designed, implemented and evaluated based on the need to answer the research question (see section 2.4.) and a constructivist world view underpinned the approaches used (data collection, analysis presentation of findings) to do so. A constructivist philosophy surrounding how we know what we know is more than theory as related to methodology; it is more pervasive and influential. It guides the study from the onset, affecting every aspect of the study from determining how to frame the purpose and objectives of the study, to what to look at and how to make sense of the data collected (Johnson, 1997). A constructivist approach is a social science method suited to study complex social phenomena as it consists of a set of interpretive, material practices that make the world visible to us. These practices transform the world by turning it into a series of accounts, including conversations, field notes, interviews, recordings and memos to the self (Miles & Huberman, 1994).

Ernest (1995) emphasizes the idea that, because every constructivist will inherently have their own perception of what their worldview is, 'there are as many varieties of constructivism as there are researchers' (p. 459). Therefore, it is essential to clearly state the philosophical principles that guided this particular study and provide examples of how the study was designed to allow for them. These are, in no order of importance, as follows. The belief that:

- it is impossible to come to the research field blank. We all come with some orienting ideas and rudimentary conceptual frameworks (Miles & Huberman, 1994);

- Knowledge is 'contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context' (Crotty, 1998, p. 42). A world view is no more than the way we interpret the world in which we exist. In layman's terms the lens we wear to see the objects around us, be they people, places or events. Our own personal history affects how we perceive new situations and respond to them. Intrinsic in this view is that the lens we use to see our world or in this case the research being conducted, has a uniquely subjective hue to it;

- Research is an interactive process shaped by the researcher's own personal history biography, gender, social class, race and ethnicity (see section 7.3.) and by those people in the setting being studied (both study participants and not) (Denzin & Lincoln, 2005).

The following section focuses on a few crucial aspects of the study that highlight how the study's design was underpinned by a constructivist world view. To begin with the use of thick description was a fundamental part of the study's mixed methods design. According to von on Glasersfeld (1995) 'to the constructivist, concepts, models, theories, and so on are viable if they prove adequate in the contexts in which they were created' (p. 7). Therefore in order to contextualize the data the study used thick description to describe the workings of the unit and the innovation journey the staff underwent whilst detailing the model of care provided on this unit.

As human beings situated in the world, our demographic characteristics alone cause us to see things from a particular class, gender, race, culture and ethical community perspective or lens (Denzin & Linclon, 1998). Understanding that knowledge is socially constructed and that meanings are numerous and diverse, the study sought the complexity of views rather than narrowing on a few specific categories, whilst at the same time embracing the need for diverse perspectives (staff and those being cared for by them) on what was occurring on the unit during the study's lifetime. The innovation journey that JON underwent was told through the staff participants' narratives. The service users' qualitative and quantitative data further assisted in documenting the success of the model being implemented on the unit.

Individuals seek understanding of the world in which they live and work, and develop subjective meaning based on their experiences. As such, the questions posed to the staff and service users were semi-structured in order to allow them to construct their own meaning of the situation occurring on the unit. Furthermore, understanding that reality is co-constructed, it was essential that the participants and I interacted together in order to make values explicit and to create the knowledge that forms the results of the study (Mertens, 2003). Whilst at the same time, being conscious to position myself in the research as my own experiences, history and culture had an effect on my interpretation of the events. This understanding resulted in the recording of sensitizing issues in a research log and the use of multiple interpreter control (see section 3.7.2.2.). Multiple interpreter control is a strategy used to improve the analysis by considering the ideas and explanations generated by an additional researcher (my supervisor) studying the data (Kvale, 1996; Johnson, 1997; Creswell & Miller, 2000).

3.4. Rationale for a case study approach

Of primary interest to this study is how JON crafted and delivered its model of intermediate care. This project did not begin as a general research question, or as a need to have a general understanding of any facility delivering intermediate care. Rather, it began as one organization's desire to fund a case study research project in order to assess their intermediate care unit. That being said, in accepting the responsibility to take on any piece of research, the researcher must acknowledge that diverse approaches to data collection and analysis exist.

When deciding upon a specific research approach one should be aware that although there are many different methodological perspectives to guide a study, there are limitations to any chosen method. Fundamental when choosing a study design is the reality that the appropriateness of a study's design is dependent on the research question. This study was multifaceted and concerned with describing the intermediate care model being implemented on this unit whilst concurrently evaluating the effectiveness of the unit's ability to meet the organization's own pre-determined success criteria. As such, the complexity of the study's objectives (see section 1.4.) supported a mixed methods approach to this single case study design by allowing me to take a comprehensive approach to describing and evaluating the intermediate care being provided at this facility.

In keeping with a constructivist orientation to knowledge, the role of interpreter and gatherer of interpretations is central to the research process. A case study approach allowed me to analyse the development of an intermediate care model through the interpretations of the service users and staff, whilst concurrently assessing the effectiveness of a nursing home based intermediate care unit to meet its own pre-determined success criteria during the first two years of functioning and describe the interpretations of the data collected using thick description (Geertz, 1973). Stake (1995) emphasizes that an in-depth case study approach allows the researcher to sharpen the search for understanding by perceiving what is happening in key episodes and present their own interpretation and stories. By presenting these interpretations or stories using thick description, as was done in this study, I was able to convey a rich picture of what was occurring on the unit during the data collection phase.

A case study approach affords a researcher the inimitable opportunity to take a particular object (be it a person, group of people or event) and come to know it well within its own environment. Two of the major proponents of case study research are Yin (2003a & b) and Stake (1995). Both researchers share many similar views, as well as differing significantly in their case study research positions, thus resulting in some confusion in the literature focusing on case study research (Appleton, 2002). Appleton (2002) clearly distinguishes between Yin and Stake's perspectives, reinforcing the need to have a solid understanding of each individual's epistemologies prior to adopting either approach. When assessing the appropriateness of Yin and Stake's approaches it was noted that, in many aspects, either Stake's or Yin's case study strategy could have been adopted for this study design. Both approaches emphasize the significance of studying a real phenomenon within its natural environment where multiple sources of evidence are used to gain an in-depth understanding of the phenomena in question (Yin, 2003a; Stake 1995). In addition, it is noted that generally the choice of a case study theorist is based on the philosophical standpoint of the theorist in relation to the research question (Gomm et al., 2000). The question being posed of this particular research study corresponded with Stake's philosophical standpoint of constructivism. However, the sole use of Stake's approach was problematic due to his underlying belief that case study research is qualitative in nature (Stake, 1995). It would have been impossible to collect the breadth of data required in the present case study and remain solely within the qualitative domain. Therefore, a decision was made to use Yin's approach which advocates flexibility and thereby encourages mixed method designs. By adapting Yin's approach to case study design, the study was able to examine a phenomenon within its real life setting using a mixed methods approach whilst not only remaining in harmony with the constructivist route of inquiry but also meeting the wishes of the funders who commissioned this study.

3.5. Rationale for using a mixed methods approach

From a theoretical perspective, constructivism is itself inherently multi-method in focus (Flick, 1998) as it values the multiple realities that people have. To acquire multiple and diverse realities, multiple methods of searching or gathering data are needed. The combination of multiple methodological practices in a single study is best understood not as a means to 'cover all aspects of a case' but rather as a strategy that adds rigour, breadth, complexity, richness, depth and credibility, to any inquiry (Flick, 1998, p. 231). A multi-method approach to data collection and analysis enhanced the trustworthiness of this study by deepening the analysis and attempting to overcome the deficiencies inherent in a single-method, single theory, study (Plano & Creswell, 2010). One of the driving factors for implementing a mixed methods approach to data collection and analysis was based on the approach's ability to provide a richer more complete picture of the unit. In this study, by engaging in multiple methods, a more reliable and diverse construction of realities occurred.

During the developmental phase of the study, it was anticipated that the use of a mixed methods approach to collecting multiple sources of data would strengthen the study by allowing multiple areas of the intermediate care service to be assessed. A concurrent triangulation design was used in this mixed methods case study to strengthen any weakness of one method with the strengths of the other and give completeness to the analysis of the data (Creswell et al., 2003; Adami & Kiger, 2005). The implementation of this design provided for a more complete picture of the unit of analysis, and its use within the study reflects my attempt to secure an in-depth understanding of the phenomena being assessed (Flick, 1998). For example the funders wanted to know if the service users were happy with the care they received on the unit and if so what part of the service were they happy with. concurrent triangulation design allowed for quantitative data to address the study's confirmatory questions and qualitative data to address the study's exploratory questions.

3.6. The evaluative nature of the study

Although predominantly descriptive, this case study provided staff and informants with formative feedback intermittently throughout the life of the study and a summative evaluation at the end. This summative evaluation was not intended to be a programme evaluation of the intermediate care service being implemented at JON; rather the aim was to comment on the performance of a small number of the most important features of the intermediate care service being implemented in order to understand the success or not of elements of this innovation. The key features that were evaluated focused strictly on the organization's own predetermined success criteria (see 3.7.2.)

During the developmental phase of the study, personal communication with the CEO of the JON Foundation revealed that the organization was looking for improvement through understanding. The overall aim of funding a research case study was to be able to make decisions and policies based on knowledge and to learn from practice in order to modify and improve effectiveness in the field of care of older people. JON's desire to be making knowledge-centred judgements in order to better their organization (and ultimately the care of older people) led to the formative and summative evaluative design that was utilized within the study.

The literature concerning evaluation clearly delineates two types: formative evaluation and summative evaluation (Scriven, 2007). A summative evaluation is focused on outcome and seeks to draw inferences about the effect of an intervention or programme at the end of the programme's activities and is predominantly quantitative in nature (Keen, 1995). Formative evaluation is a type of performance evaluation that takes place mid-performance. It has been well documented in education and training evaluation literature where it is credited with having the power to provide an assessment of an individual or organization's efforts prior to their finishing point for the purpose of sharing this information in order to improve upon their efforts (Denzin, 1970; Patton, 1986; Scriven, 1996). It can be used as a means of measuring the individual or team's success whilst providing input that will allow the team (if they so choose) to identify and correct problems in operations (Guba & Lincoln, 1989). Formative evaluation encourages a process of reflective practice by involving the parties in the evaluation process by showing the team how they are performing and allowing them to adjust their performance as need be (Mohrman et al., 1995). As this type of evaluation focuses on improving work in progress, it is not an end in and of itself but rather should be employed to the extent that it improves practice (see Appendix 2).

Evaluation within a mixed method design can take many forms and adhere to a variety of theoretical perspectives whilst differing in design complexity (Rallis & Rossman, 2003). As such, this mixed methods case study used a combination of formative and summative evaluation strategies to assess JON's ability to meet their own predetermined success criteria whilst undergoing a journey of innovation.

One of the reasons for combining formative and summative evaluation strategies in this design focused on the need to put the study's findings into context and document the changes that occurred throughout the innovation journey. This was done in order to feed back progress to the staff/informants and stakeholders at certain times throughout the study as well as comment on the care outcomes for the service users. A strictly formative evaluation lacked the summative element that the funders requested whereas a strictly summative evaluation would not lend itself to providing sufficient detail to put the findings in context and provide feedback intermittently to all parties involved. As highlighted by Pawson and Tilley (1997), within a social context, a strictly summative approach to evaluation is not a sound way of deriving sensible lessons for policy and/or practice as:

- What works to produce an effect in one circumstance may not necessarily work in another circumstance;
- Communities are not hermetically sealed and effectiveness of the measure is contingent on the context in which it is introduced. The same measure is experienced differently by those in different circumstances.

That being said, from an evaluation standpoint, the questions posed by this study did not concern themselves with what works (or will work) in intermediate care for all of NHS but rather, what worked for JON in this particular circumstance. An aim of the study was to contextualize what was occurring at JON in order to provide sufficient detail so that other practitioners, stakeholders and/or policy makers could equip themselves with the understanding of what interventions, within one community based intermediate care facility, produced what outcomes and in what circumstances, thus allowing them (practitioners, stakeholders/ policy makers) to be better able to decide what policies to implement in what conditions. As such, given the resources for this study, a mixed methods case study which contained formative feedback with a summative evaluation component was deemed to be practical and useful. The following strategies were implemented as a mean of providing formative feedback to all parties involved in the study:

1. Following the initial set of staff and informant interviews (October and November, 2007) each subsequent interview session (February and March, 2008, June and July, 2008) began with a Balanced Scorecard diagram (see 6 & 7) that was used as a 'snapshot' of specific quantitative data (chosen by the funders) at that point in time. These BSCs were accompanied by the emerging staff qualitative themes (that resulted from the preliminary analysis of the staff and informant interviews) (see section 4.6.1. & 4.6.2.).

2. Interim reports were submitted to the JON Foundation stakeholders in July 2007 and July 2008.

3. A group information session was held with staff and informants in July 2008 to discuss the preliminary findings and how staff and informants had integrated (or not) the formative feedback into their practice (see section 4.7.).

4. The JON Foundation was provided with routine progress updates as part of their Research and Education group meetings held quarterly, every year, since the inception of the study in October 2006. As of January 15, 2008 these information sessions were provided to the study's steering group.

This evaluation was designed in order to ensure the early dissemination of the findings as well as provide an opportunity for any re-shaping of care in order to maintain the best interests of the service users as the study progressed. However, the staff clearly stated at the end of the data collection phase during the group information session (see above point 3) that although helpful in justifying how they felt during the data collection phase, nothing of consequence was done with the feedback. The following quote clearly illustrates the lack of integration of the feedback: *'We were kinda waiting for management to do something with it'* (IC 101) (see section 4.7. for further detail on lack of integration of formative feedback).

Evaluators do not choose methods to collect and analyse data according to a qualitative and quantitative distinction; rather, they do so according to the questions being asked (Tashakkori & Teddlie, 2003). In this particular case, unveiling how JON implemented its unique form of person-centred intermediate care whilst meeting (or not) the controlling organization's predetermined success criteria required more than one way of thinking. The need for divergent ways of thinking led to the multiple methods form of evaluation that was employed in this study.

Although, the use of mixed methods for data collection and analysis has been promoted based on its ability to yield a more comprehensive description, one must not assume that the results of the two different methods will produce consistent findings. In this study, the different sources of data provided for a richer picture allowing for the interpretation of activities and events in context. Whilst producing sufficient detail to allow the presentation of the findings using thick description (Geertz, 1973).

3.7. Data collection

A mixed methods approach was used to explore the impact of this service from the staff and individual service user's perspective and the study gathered information that explored the consequence of purposive cultural change on the health care team. Qualitative and quantitative data collection was concurrent and equal priority was placed on the collection and analysis of the qualitative and quantitative data thereby emphasising the importance of both in the formation of a rich picture of the unit. In this section the research question is broken down into objectives in order to identify the specific components of the question and the corresponding data collection methods that addressed each aspect of the question. This is summarised in Table 3.1, which is built upon throughout the methods chapter (e.g. Table 3.3 contains analysis used for each data collection method). A detailed account of each data collection method follows the sampling strategies described in section 3.7.1.

Table 3.1 Data collection methods

Objectives of the research	Methods through which data have been collected
• Provide thick description of the construction and workings of the model of care used within one community based facility.	• Unstructured interviews informants • Semi-structured interviews staff • Document analysis • Routinely collected activity data
• Determine and comment on the impact and effectiveness of the intermediate care model that was used at JON in relation to the achievement of the organization's original predetermined success criteria, based on the following: service user satisfaction, care outcomes, process and value for money.	• Unstructured interviews informants • Semi-structured interviews staff/Service user (SU) • SU satisfaction questionnaire • Change in Barthel index scores • Document analysis • Routinely collected activity data (see Table 3.3 - detailed account of criteria & corresponding data source)
• Provide feedback on the findings locally to key stakeholders (funders, key service participants) at specific points during the study.	• Unstructured interviews informants • Semi-structured interviews staff/SU • SU satisfaction questionnaire • Change in Barthel index scores • Routinely collected activity data

3.7.1. Sampling strategies and access

A mixed sampling strategy was used in this study. The unit of analysis was the intermediate care (not respite care) component of JON's intermediate care unit. Within this unit, there was a mixed sample of subunits. These subunits were made up of informants and staff employed by the facility to work on the intermediate care unit and service users admitted to the unit who were expert witnesses to the care received whilst at JON.

3.7.1.1. Staff and informants

The nurses working on JON's intermediate care unit had a great deal of autonomy. That being said, it is important to note that JON did have medical input. At the beginning of the study's data collection phase, the services at JON's intermediate care unit were being delivered by a staff of highly qualified medical doctors (2 = 1 specialist doctor + 1 senior house officer), Nurse Manager (1), registered nurses (15), occupational therapist (1), physiotherapists (1), rehabilitation assistants (2), health care assistants (13) and social workers (2). Although a dedicated consultant in gerontology oversaw the unit's medical input and was part of the MDT, the medical staff were not interviewed for this study. The reason for this was twofold. Firstly, at the onset of this study the funders made it clear that they were interested in feedback from the nursing and rehabilitation team's point of view, not a medical perspective. Secondly, although there was a Senior House Officer (SHO) present on the unit for two full and two half-days a week, the SHOs rotated through this unit every six months (or less) as part of their vocational training schemes for GPs. As a key goal of the staff interviews was to see how this service and model of care unfolded over the year, for continuity purposes this particular group was excluded from the recruitment process. I acknowledge the risk inherent in the lack of completeness in excluding this group and the possible risk of under-representing the unit as a whole. However, the study was designed to give particular attention to exploring the nursing, care assistant and rehabilitation team's understanding of what intermediate care was and specifically what was happening on this unit from their practice perspective.

Therefore, all non-medical staff, with dedicated working hours on the intermediate care unit (nurses, rehabilitation assistants, carers), were invited to participate in the study. As previously stated, informants for this study consisted of the JON Foundation's managerial staff specifically the CEO, Centre Manager, Practice and Staff Development Manager and Learning and Development Manager. Data were gathered from a purposive sample of staff (n=12) and informants (n=4).

3.7.1.1.1. Staff and informant inclusion and exclusion criteria

Inclusion criteria:	English speaking, able and willing to express themselves, dedicated working hours at the intermediate care unit with direct service user contact or direct managerial functioning with the unit.
Exclusion criteria:	Medical staff, unable to communicate in English, temporary/agency staff, staff working at the centre with indirect service user contact (e.g. maintenance, cleaning staff).

The following strategy was undertaken as a means of gaining access to potential staff and informants. Information sessions for potential participants were held at JON. The Unit Manager was asked to inform all potential staff participants and JON's managerial staff about these. The information sessions were held in the dining room at JON and during these information sessions copies of the research proposal designed by me and approved by the University of Southampton's then Nursing and Midwifery Department's Ethics Committee, were circulated. I discussed the research purpose, design and plan for disseminating the results. Throughout the meeting, participants were encouraged to ask questions.

During this session, I emphasized that a fundamental aspect of this study was the exploration of the workings of JON's intermediate care unit. Those present were informed that semi-structured interviews (for staff) and unstructured interviews (for informants) would be used to gain an understanding of their perception of the development and implementation of JON's intermediate care model and the coming together of different professional groups. It was emphasized that individual responses obtained in these interviews would not be shared with other members of the health care team and that neither I nor my supervisors would intervene directly in workplace relationships.

The possible ethical considerations (as examined in section 3.14.) that pertained to this group were discussed with them followed by the following benefits of participating in this research study:

- The interview sessions would provide an opportunity to discuss emerging situations with the external, objective researcher.

- Acknowledgement of the participant's contribution to the research process for the potential benefit of others through wider dissemination of the findings.

As a means of ensuring respect for the individual participant's right to choose to be involved (or not) and counteracting any undue influence or coercion, the following steps were taken:

1. Emphasis was placed on the voluntary participation of staff and informant with their right to:

    - Withdraw from participation at anytime.
    - Control the disclosure of any personal information during the data collection process.
    - Be confident that privacy and security during the data collection, handling, processing, storing and destruction would comply with the Data Protection Act 1998.
    - Be confident that data would be made anonymous.
    - Choose the interview location.

2. Everyone present was given a package containing the staff and informant information sheet, a copy of the consent form, a reply slip and a self-addressed envelope. All present were asked to take a moment to carefully read the contents of their packages. The information session was then open to further questions.

3. Once all questions had been answered it was explained that there may be undue influence on staff to participate in a study when managerial staff were present for the signing of the consent form. Therefore, all present were asked to take their information sheet (see Appendix 3) home. Should they choose to participate, they were asked to complete the reply slip (see Appendix 4), which included the participant's preferred contact details and return it to me, within seven days, in the self-addressed envelope provided. Out of a potential thirty-seven, sixteen staff/informants chose to take part in the study.

Those present were further informed of the following: a formal consent form would be signed at the beginning of the first interview session; once I received the reply slips the future participants would be contacted via telephone to set up an initial interview time; subsequent interviews would be scheduled at a later date; as each participant entered the study their contact information and interview dates would be entered into a computerized tracking system.

3.7.1.2. Service users

By means of consecutive sampling, the allocation for service users commenced August 1, 2007 and ended July 31, 2008. It was anticipated that a consecutive sample of 118 service users admitted to JON for intermediate care services would be chosen for this study. The actual sample size was smaller than anticipated with 94 service users agreeing to participate in the study (the implications of this will be discussed in chapter five). The original sample size estimate was based on the following calculation. A power calculation based on a Barthel index 100 with standard deviation of 30 and a change in mean score (before versus after) of 8 points, 80% power and 5% statistical significance requires sample size of 89 for a one-tailed paired t test. The Barthel index 100 has a reliability of 0.9, therefore sample size estimate increases to 89/0.9 = 100. Adjusted upwards to allow for a potential dropout rate/refusal rate of 15%, 100*100/85 = 118. Sample size estimate took into account that a 14-bed unit with an average stay of six weeks would allow for 728 bed weeks per year and, as a result, the number of service users coming through the centre should have been 728/6 =121. At the time of the proposal, the practices on the unit (according to the Unit Manager) saw a length of stay of five weeks or less, consequently the number of service users coming through could have been 145 and upwards. It was conservatively estimated that based on an average six week stay, providing the data were normally distributed (which was originally anticipated and was in fact the case) there would be sufficient numbers in a 12 month intake to detect an 8 point change in mean score on the Barthel index.

3.7.1.2.1. Service users inclusion and exclusion criteria

Inclusion: Admitted to JON for in-patient (step up or step down) intermediate care, English speaking, able and willing to express themselves verbally and mentally able to give informed consent and participate in the study

(JON's admission criteria were based on service user(s) being able to give informed consent for their treatment and to the predicted estimated length of stay whilst at the centre).

Exclusion: Admitted to one of the three respite care beds at the intermediate care unit for respite care services.

The following strategy was implemented to gain access to service users. Upon admission to JON's intermediate care unit the Unit Manager approached the service user. After an initial explanation of the study, if the service user showed interest, the Unit Manager provided the service user with a copy of the service user information sheet detailing the study. If the service user agreed to take part in the study the Unit Manager contacted me. Twenty-four to thirty-six hours after being contacted I approached the service user with the consent form and after answering any questions they had, the service user completed the consent form.

3.7.2. Performance indicators

Any evaluation of an intermediate care model must accommodate the complexity of intermediate care provision. It must cover the person receiving care, as well as the practitioners involved and the agencies responsible for providing that care (CAT 2007). The boundaries for data collection in this study were set in order to identify clear guidelines of what needed to be described and to determine the priorities for data collection. For this study, it was vital to comment on the performance of a small number of the most important features of the intermediate care service rather than to try and look at a large number of outcomes and impose onerous tasks of data collection on the service users, informants and staff (British Red Cross, 2004).

The performance indicators chosen for this study focused on what the JON Foundation identified as their own predetermined success criteria. According to the CEO (personal communication, 2006) of the JON Foundation the intermediate care model would be successful if the service users were satisfied with the care they received (service user satisfaction), if they were treated in a person-centred manner which focused on kindness, dignity and respect (process), if they were able to 'get better' and go home (care outcomes) and if they received the kind of care they had anticipated (value for money). As the term value for money usually implies the collection and analysis of financial or cost data it is pertinent to point out at this juncture that financial success was not part of this study. Regarding value for money according to the CEO of the JON Foundation JON would be getting value for their money if the service users admitted into the unit ‘improved, returned to their home and were satisfied with the care they receive. Did we do what they wanted us to do, if we do then that is value for our money?’(personal communication, CEO, 2007). The success criteria, which are known throughout the remainder of the study as performance indicators, are therefore, service user satisfaction, care outcomes, process and value for money. The performance indicators used for this study were not an exclusive or exhaustive set; more could be selected and included to check different performances at a later date, for a different study, if required. The source of data for each performance indicator is listed in Table 3.2 and further detailed in section 3.7.

Table 3.2 Data sources for performance indicators

Performance indicator	Type of Data	Sources of data
User satisfaction	• Qualitative • Quantitative	• Semi-structured interviews SU • SU satisfaction questionnaires
Care outcomes	• Quantitative • Quantitative	• Change in Barthel index 100 • Routinely collected activity data
Process	• Qualitative • Qualitative • Quantitative • Quantitative	• Semi-structured interviews staff/SU • Unstructured interviews informants • SU satisfaction questionnaires • Document analysis • Routinely collected activity data
Value for money	• Qualitative • Quantitative • Quantitative	• Semi-structured interviews SU • SU satisfaction questionnaires • Routinely collected activity data

Various aspects of the quantitative performance indicators were displayed using what is known as a 'Balanced Scorecard Approach' (see section 3.7.3.) (Kaplan & Norton 1996) and presented to the staff, informants and key stakeholders at various times throughout the study as a snapshot of how the unit was functioning at that particular time (see Appendices 6 & 7).

3.7.3. Balanced Scorecard

A Balanced Scorecard approach was adapted for this study as a means of providing a graphical representation of how the unit was functioning during specific times throughout the study. The Balanced Scorecard Approach has been adopted by various health care organizations as a routine and regular self-evaluation of their key indicators related to the organization's performance against their objectives (British Red Cross, 2004, p. 3). Introduced into the business industries by Kaplan and Norton in the 1990s, Balanced Scorecards are tools to implement a strategy as well as to assess its effectiveness (Kaplan & Norton, 1996). This evaluation tool is intended to support a cycle of continuous quality improvement by comparing performance over time on key indicators. The visual representation produced by the card illustrates if the organization's performance is meeting the agreed targets, or identifies areas of performance that might need further investigation and action to deliver better care and support to people (See Appendix 6 and 7 for the Balanced Scorecards produced during this study).

The Balanced Scorecard approach was adapted for this study in order to provide a ‘snapshot’ of how the unit was functioning, based on the performance indicators (chosen by the funders). This ‘snapshot’ was presented to staff, informants and key stakeholders twice throughout the study’s data collection phase as part of routine formative feedback sessions (see section 3.6. and Appendices 6 & 7 for the BSCs presented). Although intended to measure the same criteria over the entire year of data collection, after the initial BSC was created it became apparent that the criteria used to measure *Process,* (measuring the amount of time before a service user was contacted by a member of JON) did not realistically portray what was happening on the unit at the time. During the initial data collection phase, the process for referring service users to the unit stipulated that unless the bed was ready and available no referral would be made; as such a waiting list was never truly generated. The *Process* category was therefore amended for the second BSC and included an area of concern that was highlighted during the initial set of staff interviews; estimated length of stay versus actual length of stay.

The aim of integrating the Balanced Scorecard approach into the formative feedback sessions was to afford the staff the opportunity to see a ‘snapshot’ of how the unit was functioning based on the founding organization’s success criteria. Section xx discusses the staff’s feedback on the BSCs and how they integrated the findings into their everyday practice and altered (or not) their practice in order to improve care.

3.7.4. Methods for data collection

3.7.4.1. Unstructured interviews with informants

It was understood that informants were crucial to providing background information on the history and structure of JON. Therefore, unstructured interviews were undertaken with members of the JON Foundation’s managerial staff (referred to in this study as informants) (n=4) to assist in meeting the following objectives of the study: a) provide thick description of the construction and workings of the model of care used within one community based facility; b) determine and comment on the impact and effectiveness of the intermediate care model in relation to process and cross-discipline/cross-agency communication and cooperation.

Unlike the fixed scheduling for the staff interviews (see section 3.7.4.2.), there was no fixed schedule for the informant interviews; rather they were held on an as-required basis in order to inform data collection and analysis. By questioning the appropriate key informant(s), I was able to ascertain what the service provision at JON was intended to be according to the controlling organization (the JON Foundation). I was able to obtain the necessary background information/logic needed to make sense of the themes that were emerging from the staff and service users' interviews by clarifying any questions regarding the organization's structure and function that arose. The informant interviewing process allowed me to contextualize the facility and service by gaining an in-depth understanding of the controlling organization's (the JON Foundation) vision, goals and direction for the unit (JON). Data from these interviews are integrated throughout the innovation journey (Chapter 4) and the discussion chapter (Chapter 6).

3.7.4.2. Semi-structured interviews with staff

Semi-structured interviews were undertaken (See Appendix 8 for interview guide) with JON staff (n=12) to assist in meeting the study's objectives, namely: a) provide thick description of the construction and workings of the model of care used within one community based facility; b) determine and comment on the impact and effectiveness of the intermediate care model in relation to process and cross-discipline/cross-agency communication and cooperation; c) provide feedback of the findings to staff/informants and key stakeholders.

Staff participants consisted of staff who had dedicated working hours on JON's intermediate care unit (a detailed account of the staff and informant sampling strategy is provided in section 3.7.1.). The interview questions for the staff were designed in order to learn more about how differing groups of professionals came together to develop, implement and review a model of care, for example, the individual's perception of what was (or not) currently working in the delivery of JON's intermediate care model. It is important to clarify that on JON's IC unit model development and implementation were an iterative process. Although the unit was providing a model of intermediate care from the first day the unit opened, what this model looked like continued to evolve as the staff implemented it. Therefore explicit questions were added to the first and last interview session in order to monitor whether the staff's perception of this model of intermediate care had changed since its inception.

Three sets of semi-structured interviews were carried out; one with each staff participant every four months over a twelve month period (October/November 2007, February/March 2008, June/July 2008). A one and a half hour time limit was placed on each interview to control for mental exhaustion on the part of the participant and myself. All interviews began by reviewing the consent form as a reminder of the participant's rights, the study's purpose and to establish rapport and enhance confidence. At each interview, the participant received a copy of the interview guide to facilitate understanding; this copy was collected at the end of the interview. The following demonstrates how the data collected and preliminarily analysed from each staff interview informed the next set of staff interviews. There were four parts to this iterative interviewing process:

1. The staff/informant was asked if they were happy to have me start the digital recorder.

2. Each interview (with the exception of the first) began by providing formative feedback on emerging themes and a model representation using a Balanced Scorecard (see section 3.6.) from the data collected since the last set of interviews.

3. The staff/informant was invited to comment on this analysis. This approach allowed me to follow-up, clarify and elaborate on the themes that had arisen during the earlier interviews.

4. Questions were then asked from the staff interview guide (see Appendix 8). This guide was developed from a review of previous literature on the care of older people, measurements of service user's satisfaction, published work evaluating intermediate care and collaborative practice.

Each interview was audio-taped and conducted in a dedicated private interview room. A choice of three private interview rooms was offered:

1. on the unit;

2. off the unit, but still within the JON complex;

3. at the University of Southampton's Highfield campus.

When the interview was complete, the staff/informant received a brightly coloured coded reminder card with my contact details and the time and location of the next interview. The staff/informant was reminded that they would receive a phone call one week prior to the next interview as a courtesy call.

After each interview, post-interview summaries were recorded and included information about the characteristics of the interview setting, behaviour of the participant, notes about the interview (e.g. length of the interview, interruptions or distractions) my reactions to the interview, main themes or issues suggested by the interview, the question that provoked the strongest response and thoughts about new or remaining questions stimulated by the interview. All data were organized and stored in a specified database (see section 3.11.).

To develop sensitive interviewing techniques I attended various training sessions (e.g. in-depth interviewing skills) and applied what Kvale (1996) refers to as 'multiple interpreter control' to analysis by having early interviews and randomly selected subsequent interviews reviewed by one of my supervisors with feedback to me. These strategies assisted in promoting the improvement of my interviewing skills, validating the data collected and maintaining control over the large amount of complex interview material collected (Kvale, 1996).

3.7.4.3. Semi-structured interviews with service users

A sample of 94 service users participated in the study (a detailed account of the service user sampling strategy is provided in section 3.7.1.). Semi- structured interviews with service users assisted in meeting the study's following objectives: a)determine and comment on the impact and effectiveness of the intermediate care model in relation to service user satisfaction, process and value for money b) provide feedback on the findings to staff/informants and key stakeholders at specific points during the study

In order to identify and explore the service users' perception of the care they received on the unit, two semi-structured interviews were conducted (upon admission and at the time of discharge). Once a service user had been identified by the Unit Manager as wanting to take part in the study, the Unit Manager contacted me. Once contacted I ascertained from the Unit Manager if the service user appeared comfortable and well enough to approach; if so, I contacted the service user 24–36 hours after admission. Following an explanation of the study and the formal completion of a written consent form, the service user was then interviewed in their private room on the unit (see Appendix 9 for a copy of the interview guide).

Following notification of discharge, and prior to leaving the centre, the Unit Manager contacted me to provide an update on the service user's impending discharge. Once notified of the discharge status a follow-up interview with the service user took place in their private room on the unit. At that time, each service user was reminded that the information they gave would be kept anonymous and would in no way affect the care they were still receiving at the centre or any future care. The answers the service user gave to the initial question of 'what do you expect from the service here at JON' (posed to them during the first interview) were re-read and then they were asked to comment on their initial answer in regards to the care they received during their stay at the centre. For example, at the time of discharge the service user was read what they originally said they were anticipating from the service on the unit. They were then asked to comment on this based on their experience on the unit e.g. 'In your first interview you said you wanted the staff here to help you be more independent and walk better. Tell me about the care you received on this unit and your current ability to be more independent and walk again.' This answer was recorded manually then transcribed following the data management protocol (see section 3.11.).

3.7.4.4. Service user satisfaction questionnaire

The service user questionnaire, which was chosen for this study, is a questionnaire developed specifically for use in intermediate care (Wilson et al., 2006). Service user satisfaction is an important consideration in service development and this questionnaire was developed specifically to include the key elements of satisfaction with intermediate care services. The results of this questionnaire assisted in meeting the following objectives of the study: a) determine and comment on the impact and effectiveness of the intermediate care model in relation to service user satisfaction, process and value for money; b) provide feedback of the findings to staff/informants and key stakeholders at specific points during the study.

This theoretically based questionnaire (see Appendix 10) had been shown to be feasible to administer by interview, and reliable and valid (test re test reliability Kappa= 0.2-0.4 for 6 questions, scores correlated with the Client Satisfaction Questionnaire Spearman's r= 0.75, p<0.001) (Wilson et al., 2006). During the second interview, once the interview question had been completed, a copy of this satisfaction questionnaire was given to the service user. Using a face-to-face technique, the purpose of the questionnaire was explained and the service user was asked to complete it. It was acknowledged that this form of questionnaire administration has been criticised for its potential to be considered intrusive and reactive, and there exists the possibility for social acquiescence. However, this form of administration has also been credited with its ability to collect reliable, unbiased, valid data. In order to administer the questionnaire in a timely manner and within the given resources of this study a face-to-face presentation was deemed to be the most appropriate mode of administration (McColl et al., 2001). Nonetheless, I remained attentive to the potential disadvantages of this form of administration when overseeing the completion of the questionnaire.

Data collected through these interviews were triangulated with other qualitative (i.e. interviews with staff and informants) and quantitative data (i.e. Barthel index 100 scores) as this provided a more complete picture of the effectiveness (or not) of the intermediate care model being implemented at JON's intermediate care unit.

3.7.4.5. Change in Barthel index 100 score

Intermediate care is a service that aims to facilitate a move from medical dependence to functional independence, with the main emphasis being the promotion of independence through active recovery (HTA, 2004). Therefore change in functional independence was deemed of value to the study of this unit's intermediate care model. Specifically, determining the service users' level of functioning (at the time of admission and at discharge) using the Barthel index 100 assisted in meeting the study's following objectives: a) determine and comment on the impact and effectiveness of the intermediate care model in relation to process and value for money; b) provide feedback of the findings to staff/informants and key stakeholders at specific points during the study.

The second objective of this study was to determine and comment on the impact of the effectiveness of the intermediate care in relation to the achievement of the foundation's predetermined success criteria, specifically in this section, care outcomes and value for money. One manner in which care outcomes were evaluated was by measuring any change in functional ability. Functional ability was measured using the Barthel index 100, a validated functional ability tool. The Barthel index 100 is a renowned standard rehabilitation assessment tool that can be used to assess improvement in functional ability (Hsueh et al., 2002). It is said to be at its best when recorded over periods of time by a single individual, as an assessment of improvement. When compared to other scales it is credited with possessing certain advantages that include completeness, sensitivity to change, amenability to statistical manipulation and greater familiarity due to its widespread use (Gresham et al., 1980). As an index of independence, it is useful in determining a baseline level of functioning and can be used to monitor improvement in activities of daily living (ADL) over time.

The Barthel index 100 consists of 10 items that assess a service user's daily functioning, specifically their activities of daily living and mobility. The items are weighted according to a scheme developed by the authors (Mahoney & Barthel, 1965). The service user receives a score based on whether they have received help whilst completing the assessed task. The scores for each of the items are summed to create a total score. The higher the score, the more independent the person is deemed to be.

The Barthel index 100 is considered to be the best of the ADL assessment scales. However, there are other assessment tools – Functional Independence Measure (FIM), The Lawton Instrumental Activities of Daily Living (IADL) Scale – that have been noted as being more sensitive to small changes in functional independence (van der Putten et al., 1999; Hobart, 2001). The rationale behind choosing to use this particular scale was threefold. Firstly, the staff at JON were familiar with the scale. It was noted during the study's developmental stage that each service user was to have a Barthel index 100 completed by their admitting nurse as part of their overall nursing admission assessment. Secondly, the Barthel index 100 has been used in previous studies of intermediate care and as such allows for comparison with other studies (Steiner et al., 2001; Griffiths et al., 2000, 2001). Thirdly, the sensitivity of the Barthel index 100 can be improved upon by expanding the number of categories used to record improvement in each ADL function (Shah et al., 1989). The modified scoring of the Barthel index 100 achieves greater sensitivity and improves reliability without causing additional difficulty or affecting the implementation time. In a study conducted by Shah et al. (1989), the internal consistency reliability coefficient for the modified scoring of the Barthel index 100 was 0.90, compared to 0.87 for the original scoring. Given the above stated positive claims of greater sensitivity and reliability, as well as the unit's familiarity with the index, it was concluded that this assessment tool was the best possible fit for this study and therefore, the modified version of the index and its guidelines were applied in this research.

Following the standardized guidelines for its administration, each service user, with the assistance of the service user's primary care nurse, had a Barthel index 100 completed during their admission interview or at the latest, once they were enrolled into the study during the initial data collection phase. This was completed. In a study conducted to investigate the reliability of four different methods of obtaining the Barthel index 100 score (self-report, asking a trained nurse who had worked with the patient for at least one shift, and separate testing by two skilled observers within 72 hours of admission), the results indicated that asking an informed nurse or relative was as reliable as testing the patient themselves (Collin et al., 1988). The Barthel index 100 was repeated when the service user had been notified of discharge and prior to leaving the centre. Once again, the completion of this scale was done with the assistance of the primary care nurse. The change in Barthel index 100 score was the difference between the score at the time of admission and the score at the time of discharge.

3.7.4.6. Document analysis and routinely collected activity data

The documents of interest to this study consisted of various organizational reports held within the JON Foundation (e.g. annual reports). Along with these documents a review of the demographic features of the study's participants was deemed important in terms of assisting in meeting the following objectives of the study: a) provide thick description of the workings of the model of care used within one community based facility; b) determine and comment on the impact and effectiveness of the intermediate care model in relation to care outcomes, process and value for money, admission/re-admission rates to hospital/residential long term care; c) provide feedback on the findings to staff/informants and key stakeholders at specific points during the study.

The following data were collected in order to document the characteristics of the service users that were receiving care on this unit during the study's timeline.

- Age
- Ethnicity
- Diagnosis category upon referral to the unit
- Summary of care services required prior to admission to the unit
- Location prior to being admitted to the unit
- Estimated length of stay on the unit
- Admission Barthel index 100 score

The following data were collected regarding the participants' outcomes and how the results compared to their admissions' status. Specifically:

- Actual length of stay
- Discharge care package
- Change in Barthel index score
- Summary of care services required at discharge from the unit
- Six week follow up location

The following data were deemed essential to understanding the effectiveness of the service at JON. One of the driving factors in the development of intermediate care service was to prevent premature or unnecessary admission to long term residential care. Therefore, data supporting discharge destination and where the service users were six weeks after they were discharged from the service was collected. This data consisted of:

- Destination following discharge from the centre

- Admission/re-admission rates to hospital/residential long term care

- Six week follow up location

3.8. Data analysis

Data analysis is the process of organizing and synthesizing the data collected in order to use the interpretation of this data to answer a research question(s). When attempting to ‘make sense’ of the data collected, the analysis must remain ‘soundly based and thorough’ (Silverman, 2005). In order to do so the data collected in this study were analysed using a consistent and logical approach.

Case and context are infinitely complex, investigating a contemporary phenomenon within its real-life context when multiple sources of evidence are used can generate a considerable amount of data (Gomm et al., 2000; Yin, 2003). Such was the case in this study. However, through the process of progressive focusing the breadth of the inquiry was systematically reduced and concentrated attention was then given to the emerging themes. Table 3.3 builds on Table 3.1 by identifying the general types of analysis that were used to address each objective of the study. The text that follows Table 3.3 provides specific details of each analysis (e.g. inductive thematic analysis, specific statistical test, et cetera).

3.8.1. Qualitative analysis

Staff, informants and service users’ interviews were transcribed verbatim from audiotapes onto computer files. The written transcriptions generated from each session were compared with the audiotapes from the original taped interviews for accuracy. During this process of checking for accuracy, I was able to make note of any notable non-verbal communication that had occurred during the interview. This allowed for the revisiting of the data in its original form as many times as was needed in order to interpret the data. Data from the corrected interviews were then entered into NUDIST (software package used to support qualitative research projects) and this data underwent inductive thematic analysis.

Thematic analysis is a process of encoding qualitative data requiring an explicit 'code' (Fisher, 2005). The code in this study consisted of a list of themes. There are three methods by which themes can be developed. They are:

1. generating themes inductively from the raw information
2. generating themes deductively from theory
3. generating themes from prior research (Boyatzis, 1998)

During this study the inductive method of thematic analysis was used to interpret the staff interviews. This method guided the analysis of the themes implied by the service users, informants and the staff's understanding of what was happening on the unit during the data collection phase. Specifically, the qualitative information generated from the interviews was transformed into themes by way of thematic analysis, which consisted of encoding the qualitative data in order to use the data in a systematic manner (Fischer, 2005). This systematic manner provided a way of: 'seeing' the data; 'making sense' out of seemingly unrelated material; analysing qualitative information; and systematically observing a person, an interaction, a situation or a culture (Boyatzis, 1998).

The process of encoding qualitative data required an explicit 'code'. In this study, the code consisted of a list of themes which emerged from the qualitative data and assisted in describing and organizing the information presented in the interviews. Coffey & Atkinson (1996) note that although coding is a way to relate to the qualitative data and provides many benefits in the organization, processing and analysis of the data, coding is not necessarily a conceptual scheme in and of itself. The interpretation phase of the research followed the development and use of the thematic analysis.

During the analysis, the data underwent three levels of readings: literal, interpretive and reflexive (Mason, 2007). During the literal reading, the transcripts were read to identify the words and language used, the form and structure of the dialogue, the sequence of interactions and the literal content. Once this was complete the transcripts then underwent an interpretive reading which involved reading through and then beyond the data in order to document a version of what I believed the data meant or represented or what could be inferred from those particular data. This was done in order to gain an understanding of the participants' interpretation of what was occurring on the unit. Finally, the data underwent a reflexive reading in order to account for my involvement in its generation and interpretation. The findings of this reflexive reading will be presented in chapter 7.

Following the reflexive reading, indexing categories were applied to the data. The indexing of the data allowed: a) for the distancing of the researcher in order to remove myself from the memorable elements of the interview and gain a more measured view of the whole interview; b) for the retrieval of topics and information that did not occur in a sequential manner within the data; c) the development of themes to occur; d) a sense of the scope and coverage of the data. The indexing allowed for a systematic retrieval of data when thematically analysing across the interviews. The iterative process of this data analysis meant that as an 'unfinished resource' each grouping was loose and flexible (meaning the grouping of data could be altered at a later date) and was seen as a starting point on which to ask further questions of the other interviews within that set, as well as leading to potential questions to be posed to the participants during the next set of interviews, always ensuring detail to the context in which the grouping occurred (see Appendix 11) (Mason, 2007). The data were further reduced and classified as they underwent constant comparison with one another (e.g. one staff interview with another staff interview) in order to identify uniformities and variations. The direct interpretation of other data (e.g. informant interviews, routinely collected data) allowed for the understanding of the themes in context.

3.8.2. Quantitative analysis

The function of the quantitative data analysis was twofold, firstly to measure the effectiveness of JON's model of intermediate care in relation to service users' outcomes. Answering questions such as, did they improve, did they go home, and were they happy with the care they received. Secondly, the quantitative data assisted in contextualizing all the data collected in order to provide a thick description on this model of care and how it was being implemented on the unit.

In order to assess the data in relation to the JON foundations predetermined success criteria and provide the necessary data to describe this unit in detail the quantitative data underwent the following analysis. Descriptive analysis was carried out on key baseline characteristics and service user outcomes. Measures of central tendency and dispersion were calculated and presented in tabular and graphical format. A one-tail paired-sample t test was used to test for an improvement in scores from admission to discharge (i.e. becoming more independent) and whether this shift was statistically significant. The power calculation for this change was based on a Barthel index 100 with standard deviation of 30 and a change in mean score (before versus after) of 8 points, 80% power and 5% statistical significance and a sample size of 89 participants.

3.8.3. Triangulated analysis

According to Yin (2003) case studies need not be limited to a single source of evidence. He puts forward the argument that case study findings can be based on a convergence of information from both quantitative and qualitative sources. In keeping with the concurrent triangulation design (Creswell et al., 2003), triangulation was used in the analysis phase to integrate the qualitative and the quantitative data sets. The word triangulation was originally incorporated into social science research as a metaphor used to describe the combining of multiple methods to evaluate a single construct (Shih, 1998; Halcomb & Andrew, 2005). Simply put the process of triangulation has become characterized by the combination of two or more theories, data sources or methods. The authenticity of combining quantitative and qualitative methodologies has been the subject of great debate over the last decade with the emergence of mixed methods as a third methodological position. According to some scholars triangulating qualitative and quantitative methodologies has gained more recognition recently with the advancement of mixed methods as a legitimate third option to research (Tashakkori & Teddlie, 2003; Johnson et al., 2007; Sosulski & Lawrence, 2008).

Within a mixed methods study applying a concurrent triangulation approach allows a study to analyse the evidence collected from asking the same question of multiple sources of data and to use the convergence of the qualitative and quantitative findings to strengthen the knowledge claim or to explain the lack of convergence that may occur (Yin, 2003a). For example, within this study, regarding care outcomes, the staff were asked for their perception on whether the care they delivered helped the service users to improve; the service users were asked for their perception of whether or not they improved and finally the change in Barthel index 100 scores underwent statistical analysis to check for a significant increase in score. This was done in order to either 1) strengthen the claim, i.e. yes, the staff felt they were providing effective care, yes the service users felt they received effective care and improved and yes, there was a statistically significant increase in Barthel index 100 scores or 2) explain the lack of convergence that may have occurred, i.e. the staff felt they were not providing effective care, the service users felt they were receiving effective care and improving and the Barthel index 100 showed no statistically significant change in scores. In this study the lack of convergence that occurred between the two data sets dominates chapter 6.

During the study's analysis phase, the use of this concurrent triangulation design afforded the study the opportunity to:

- use triangulation to seek convergence and corroboration of results from different methods studying the same case;

- use the data sets in a complimentary manner in order to seek elaboration, enhancement and clarification of the results from one method with the results from the other;

- use the results from one method to assist in informing the other method (e.g. the quantitative data presented in the BSC were presented to staff during the interview session and they were asked to comment on this data);

- expand the breadth and range of inquiry by using different methods for different inquiry components (Green et al., 1989) (qualitative data addressing the iterative process of model development/implementation occurring on this unit and quantitative data detailing service users' outcomes).

A mixed methods design gives the study the capability to 'get more out of the data' by generating more meaning which in turn can enhance the quality of the data interpretation (Onwuegbuzie & Teddlie, 2003). Therefore, when implementing a mixed methods design a researcher must be cognizant that if different methods are used to investigate the same phenomena the resulting findings may contradict one another. Because of this, applying qualitative and quantitative methods at the onset of a study design in order to later combine the findings, to enhance the representation of the findings and allow adequate explanation of the phenomena being studied, is not a sound methodological concept for the integration of mixed methods (Erzbergen & Kelle, 2003; Bryman, 2007; Plano, Clark & Creswell, 2010). In this case the 'Popperian falsification concept' of theory modification can be applied; the utilization of different methods of inquiry to search for divergent findings in order to unearth new and enhanced explanations of the phenomena under investigation may allow the researcher to set up the 'dissonance, doubt and ambiguity that is often associated with creative intellectual insight' (Rossman & Wilson, 1985, p. 87; Erzbergen & Kelle, 2003). In other words the divergence of findings should not be arbitrarily seen as a fault of the study design as the findings may point to new theoretical insights (Erzbergen & Kelle, 2003).

Various options in analysing mixed data sets exist, such as quantifying qualitative data or qualifying quantitative data. Moreover, priority can be given to one method over the other. However, the concurrent triangulation design adopted for this study ensured that equal priority was given to both methods (see Figure 3.1.).

3.9. Presentation of the findings

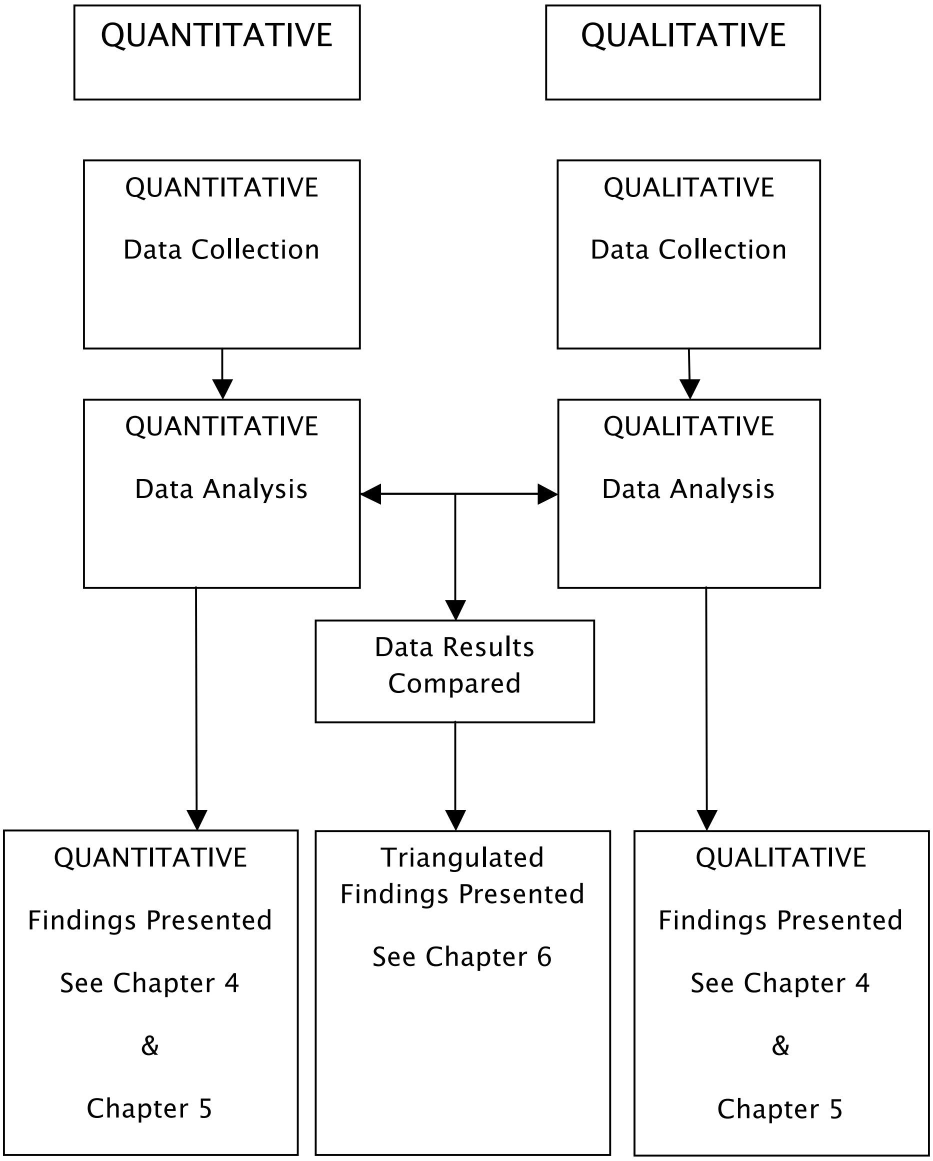
The presentation of mixed methods findings can be challenging and overlooked in the developmental phase of a study. According to Sandeloski (2003) a major criterion in evaluating the intrinsic worth of a study lies in the ability of writers to 'persuade readers of its merits in their research reports' (p. 321). This can be challenging when addressing a mixed methods audience as qualitative and quantitative readers bring different reading backgrounds, experiences and expectations with them and as such interact differently with the text presented in the report. It has been argued that in assessing the validity and trustworthiness of a study it is just as important to collect the proper data and follow the appropriate analysis as it is to present the findings in a transparent manner which can be understood and appreciated by all parties involved (Eisner, 1985; Golden-Biddle & Locke, 1993).

The structure for reporting the findings of a mixed methods study should follow the strategy chosen for the data collection and analysis of that study (Creswell et al., 2003). In other words for a concurrent study such as this one, the qualitative and quantitative data were collected and analysed separately. The findings from these data sets were then triangulated in order to expand upon the individual analysis (see Figure 3.2). As such the individual analysis should appear separate, with the triangulated analysis and interpretation of the triangulated results being presented together. The presentation of this study's findings occurs in a modified version of this structure.

The qualitative data collected from the staff and informants' interviews is presented in chapter 4 alongside various descriptive data in order to provide thick description of the unit and expose the innovation journey JON underwent in implementing their new model of care. The remaining qualitative data (service users' interviews) are presented in chapter 5 alongside the remaining quantitative data that focuses on the service users admitted to the unit and their care outcomes. Both qualitative and quantitative data in chapter 5 are presented separately from each other but are combined within one chapter in order to assist in providing thick description to answer the research question – what does a community based nursing home intermediate care model that seeks to integrate health and social care providers, voluntary and public sectors, look like and what are the key elements of its success? The triangulation of all the quantitative and qualitative data led to the findings that are presented and discussed in chapter 6. Figure 3.2 assists in elucidating the process the data underwent and the ultimate location of the findings.

I

Figure 3.2 Data flow



This order of presentation was chosen to expose the findings in a transparent, logical manner based on what the findings were saying about the unit and by no means represents any underlying order of importance to either data set. The specific structure for presenting the findings in this study was driven by the knowledge that the staff's narratives explained chronologically how the innovation unfolded. Furthermore, the quantitative data and service users' feedback spoke to the study's ability to measure the progress of this innovation based on the founding organization's key indicators for success (see section 3.7.2.).

3.9.1. Organizing framework

3.9.1.1. Van de Ven et al.'s innovation journey model

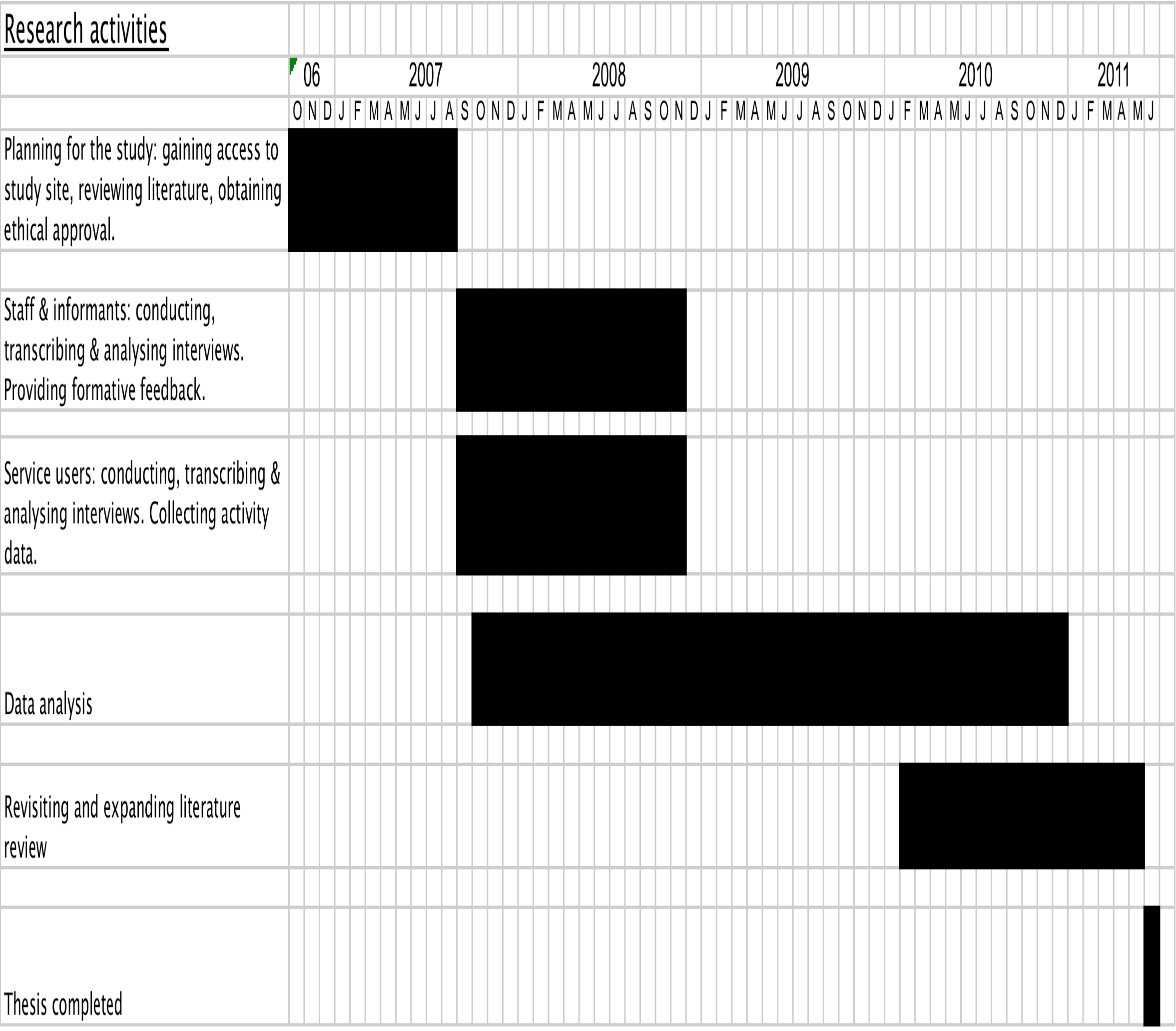
During the developmental phase of this study it became evident that a meaningful discussion of JON's innovation would require the selection of a unified perspective or model. The model itself was not a finding, rather a way in which to present the findings. The original background literature review of the organization suggested that JON was developing its own unique model of person-centred intermediate care independent of any existing model. As the study progressed the analysis of the data indicated that the journey JON underwent whilst developing and implementing its own innovative model of care lacked a simple, unitary and progressive pathway. It was fraught with multiple ideas diverging into paths that spun off in various directions, some that were related and correlated and some that were not. The result being a blurring of new and old practices in the formation of a new model that was unique to this unit and the staff delivering it. Although many existing innovation process models are linear in nature, Van de Ven et al. (1999) propose a model that presents innovation as a complex, non-linear, dynamic process in which seemingly haphazard and dependent processes are part of a non-linear dynamic system.

The journey that JON underwent whilst developing their own model of care mimicked the actions and behaviours described by Van de Ven et al.'s (1999) classic study of innovation (see section 4.2). Therefore the model of innovation proposed by them (see Figure 4.1) has been adapted for this study. This model has been used in this study to map the journey JON underwent whilst developing and implementing its PCIC model.

3.10. Study timeline

The study designed was iterative in nature. Each phase of the study had its own cyclical process of planning, fact-finding and analysing and actions in one phase of the study informed those of another. Figure 3.3 illustrates a Gantt chart showing this timeline.

Figure 3.3. Gantt chart showing study timeline



* Study temporarily halted from March 2009- January 2010

3.11. Data management

The procedure for handling, processing, storing and destroying the data collected during this study complied with the Data Protection Act 1998. All computer files were kept password protected. A database was used to track the process of:

- transcribing staff and informant interviews from the audio-tapes, checking the typed transcriptions, and erasing verified transcriptions;

- transcribing various socio-environmental context variables;

- transcribing demographic variables;
- transcribing service users' interviews;
- making weekly routine backups of all data and files.

3.11.1. Risk assessment

A risk assessment in line with the University of Southampton's School of Health Sciences' policy was completed.

3.11.2. Access to setting and equipment

Permission was sought and granted from the JON Foundation to conduct research at JON. All necessary equipment was on loan from the University of Southampton's School of Health Sciences' research department.

3.12. Quality of data and missing data

Missing data were carefully monitored. At the onset of the study, the anticipated reason for missing data were:

1. The staff or informant(s) or service user(s) dropped out of the study.
2. The service user(s) died whilst being cared for at JON.
3. I was unaware of the service user's discharge.

There were no missing qualitative data. The specific data that were missing are presented in chapter 4 and 5 alongside the collected data. The implications for this missing data are discussed in full in chapter 6.

As a means of ensuring the quality of the data during analysis I remained reflective, gave attention to negative cases and was wary of any obvious partisanship that may have occurred. In order to enhance self-awareness, I kept a field diary in which sensitizing issues were recorded; these issues will be presented in the final chapter of this thesis. To enhance the validity of the study, following preliminary analysis, emerging themes were presented to the staff and informants at the beginning of each subsequent interview session as formative feedback. The participants were asked to comment on how the summary of the major themes emerging from the data analysis reflected their practice. Data collected during formative feedback sessions were transcribed, underwent thematic analysis and were reviewed by one of my supervisors with feedback to me as a form of multiple interpreter control (see section 3.7.4.2.).

3.13. Transferability

For those engaging in qualitative research, transferability is best thought of as a matter of fit of one situation or event to another situation or event which one might be interested in comparing (Schofield in Gomm et al., 2000). The transferability of this study has been enhanced by providing a thorough description of the research in context which has allowed (in the final chapter) a comparison of the study's findings with other studies in the field of intermediate care. The goal of contextualizing JON's model of care made the inclusion of thick description vital, as the study moved outside the unit of analysis itself, by asking comparative questions during the final chapter. The use of thick description allowed the study to make an informed judgement about whether there was a true fit or not with other similar studies. This stage of evaluation has been seen to be of the utmost importance, as through comparison a study can present judgements about the merit of the unit of analysis in relation to a standard, be it a relative or an absolute one (Greene et al., 1989).

3.13.1. Credibility

One of the aims of this study was to describe what was occurring on the unit from the staff/informants' and service users' perspectives. As such, these participants were the only ones who could legitimately judge whether the results were credible or not.

In order to establish that the results of this research were credible from the perspective of the participants, the preliminary analysis of the staff/informants' interviews was fed back to staff and informants at various stages throughout the year of data collection. Participants were asked to comment on the data/themes presented. Furthermore, multiple interpreter control was used during the analysis phase by having early interviews and randomly selected subsequent interviews reviewed by one of my supervisors with feedback to me (Kvale, 1996).

3.13.2. Dependability

Dependability is based on the assumption that if the study was replicated under the exact same conditions, the same findings would emerge. The concept of dependability emphasizes that the researcher is transparent in all stages of the study, accounting for any and all amendments to the design that may have occurred and if and how these changes affected the study. Although it would be impossible to replicate this study under the exact same conditions, transparency is still essential in order for a third party to be able to look at the data collected and come up with the same results. This study maintained transparency throughout and provided a range of examples (see Appendix 1 literature search process, Appendix 11 example of thematic analysis) to assist others in following the intellectual journey that resulted in the study's findings.

3.14. Ethical considerations

The following are the key ethical considerations (and how they were dealt with) that were identified during the planning phase of the study. These were presented on July 30, 2007 to and accepted by the University of Southampton's then School of Nursing and Midwifery's Ethics Committee.

As interviewing is an interactive data collection technique, through close interpersonal interactions with all participants, there was a risk of counter transference in which a researcher, when interviewing, may project her own thoughts or feelings onto a participant. In this study a conscious attempt was made to maintain a professional distance and report the findings in a full, unbiased manner (Kvale, 1996). The principle of informed consent by staff/informants was not without problems. It was acknowledged that a manager's consent to a study may imply a more or less subtle pressure on employees to participate. Therefore, management and staff were asked to complete the consent form in the privacy of their own home and return it to me in the self-addressed envelope provided within seven days of the initial information session.

It was acknowledged that full information about the study and its design would assist in ruling out any deception of the participants. The participants were informed during the initial information session and via the information sheet that whilst the data were anonymous they may be able to recognize themselves in the data; however, the data would be made anonymous in such a way (removing all names, professional grades and professional designations) that others would not be able to identify them. However, during the developmental stage of the study it was acknowledged that meeting full disclosure would be difficult as the design of the study could possibly change in regards to the semi-structured interviews. As the interviews progressed, they would rely on following up unanticipated leads from participants and of posing questions not prepared in advance; as during field research an important approach was following up on unanticipated leads. Throughout the investigation I used a continual dialogue approach to informed consent by asking participants at the beginning of every interview session if they were still willing to be involved in the study (Kvale, 1996).

Participants were informed that any information they provided was being kept confidential. No data were presented alongside any demographic or descriptive information, and all identifying features (e.g. name, title, professional grade and professional group) were removed from the data. In order to maintain the anonymity of the participants during the writing up and presentation of data, all participants received an identification code. No material easily leading to identification (e.g. name, professional designation, coding system) was kept with the data or used in the data analysis or during the feedback sessions. Furthermore, given the case study nature of this research there were times when individual participants could recognise themselves in the data.

In regards to the service users during the first interview session, prior to signing the consent form, it was reiterated (originally communicated by the Unit Manager and written in the information package) that their involvement in the study would by no means affect their present care or any care they would receive in the future at JON or any health care institution. Additionally, if they chose to be involved, all information they gave would be kept anonymous with no data being presented alongside any demographic or descriptive information and all identifying features (e.g. name, age, address, diagnosis, et cetera) would be removed from the data. In order to maintain the anonymity of the service users during the writing up and presentation of data, all service users received an identification code and no material easily leading to identification (e.g. name, age, address, diagnosis, family physician, et cetera) was kept with the data or used in the data analysis or during the feedback sessions.

Following their initial consent, it was acknowledged that throughout the course of their stay, on the unit, circumstances could change and service users, although initially willing to take part in the study, could change their mind. Service users were informed should this occur they were to notify their nurse, who in turn would notify me, and their withdrawal from the study would take place without prejudice. In addition throughout the investigation I used a continual dialogue approach to informed consent, asking service users at the beginning of their discharge interview if they were still willing to be involved in the study (Kvale, 1996).

Finally, the formative nature of the evaluation provided feedback to the JON Foundation and staff participants at specific points during the study. This was done to ensure the validity of the data and to provide early dissemination of the findings in order to provide an opportunity for re-shaping of care so as to maintain the best interests of service users as the study progressed. In order to ensure careful attention was paid to detailing this formative feedback, quarterly meetings were held with the JON Foundation's Education and Research Group and the study's steering group (which was made up of members of the JON Foundation Education and Research group) to discuss the study's progress and the preliminary findings prior to presenting them to the staff on the unit.

3.15. Summary of the chapter

This chapter has provided details of the philosophical and methodological frameworks that shaped this study. As this is a discrete case study, I do not claim that the findings can be generalized to all intermediate care facilities functioning within the UK. The purpose of this case study is not to represent all intermediate care facilities: rather to represent this particular facility. According to Lincoln and Guba (2007), for those engaging in qualitative research, transferability is best thought of as a matter of fit of one situation or event studied to another situation or event to which one might be interested in applying the concepts and conclusions of the study. Conceptualization made the need for thick description crucial since without it the study would not possess the necessary information to make an informed judgement about how (or if) this study compared to other intermediate care findings. An experience in one situation can be transferable to another situation if the two situations have a contextual ‘fit’ with one another. The said experience (process/model) can then be applied and tested in another situation to see if the results are the same.

The use of thick description allows this study’s explanation of this model of PCIC to add to the wider body of intermediate care by identifying in detail the methodology used and adhering to the theoretical framework proposed. Furthermore, it provides sufficient details for the study to be replicated elsewhere if the results are favourable (Lincoln and Guba, 2000; Mason, 2007) or in the case of unfavourable results it provides sufficient detail for others to see where the unit may have gone wrong.

CHAPTER 4

A PERSON-CENTRED INTERMEDIATE CARE INNOVATION JOURNEY

4.1. Introduction to the chapter

The data collected from this study were of two kinds, data collected from service users admitted to the unit and data from informants and staff working on the unit. The service users' data spoke to the effectiveness of the model of care being implemented on the unit and is presented in chapter 5. The service users were a fluid group of participants that changed throughout the study, whereas the staff and key informant participants were more or less a consistent group and thus spoke to how working on the unit developed over the year long data collection period. The staff and informant data are therefore the focus of this chapter.

All non-medical staff with dedicated working hours on this intermediate care unit, were invited to participate in the study. The end sample consisted of nurse(s) and carer(s), therapist(s) and social worker(s) that came from all three groups, as well as the JON foundation's CEO, Centre Manager, Practice and Staff Development Manager and Learning and Development Manager who made up the informant group. As stated in section 3.7.1.1. the interviews with staff occurred on a set basis and those with the key informants took place in order to contextualize and/or clarify findings and queries that emerged from the staff interviews. For example, during one set of interviews some staff were adamant that the service being provided at JON was meant to replace the care previously provided at a local community hospital that closed down. Key informants were asked to clarify the purpose and intention of this unit in regards to the re-provision of services from this community hospital.

During data collection three sets of semi-structured interviews took place with the staff group of participants. This was done in order to expose what was occurring on the unit at various stages as the staff travelled through this period of innovation. The interviews were of equal importance and were scheduled every four months in order to uniformly divide the data collection period, not as a beginning, middle and an end – rather, as snapshots of what was occurring over a year-long period during the unit's first two years of functioning. The findings that emerged from these interviews exposed the innovation journey that the staff travelled whilst developing and implementing their own unique form of intermediate care. In order to appreciate the various intricacies of JON's journey Van de Ven et al.'s (1999) innovation journey (IJ) model has been used as an organizing framework in which to present some of the findings within this chapter. As a whole the chapter:

1. describes Van de Ven et al.'s (1999) innovation journey model and how it relates to JON's innovation journey;

2. details JON's innovative PCIC model that was being implemented on the unit in order to expose its innovative qualities;

3. uses thick description to describe the physical layout and various other aspects (e.g. admission policies) of JON. This has been done to assist in meeting the study's aim of providing sufficient detail to ensure an understanding of the workings of the unit and to contextualize the qualitative findings from the staff interviews;

4. describes in chronological order the themes that emerged over the course of the study from the staff interviews. These themes depict from the staff's point of view how the unit was functioning during their innovation journey. These qualitative findings are presented in detail as they highlight the proliferation of ideas and activities that occurred as the staff on this unit proceeded through the developmental and implementation periods of their innovation journey;

5. presents an in-depth discussion of group functioning and Tuckman's (1965) Stages of Group Development model with examples from JON's team. This has been included in order to appreciate how the amalgamation of these three

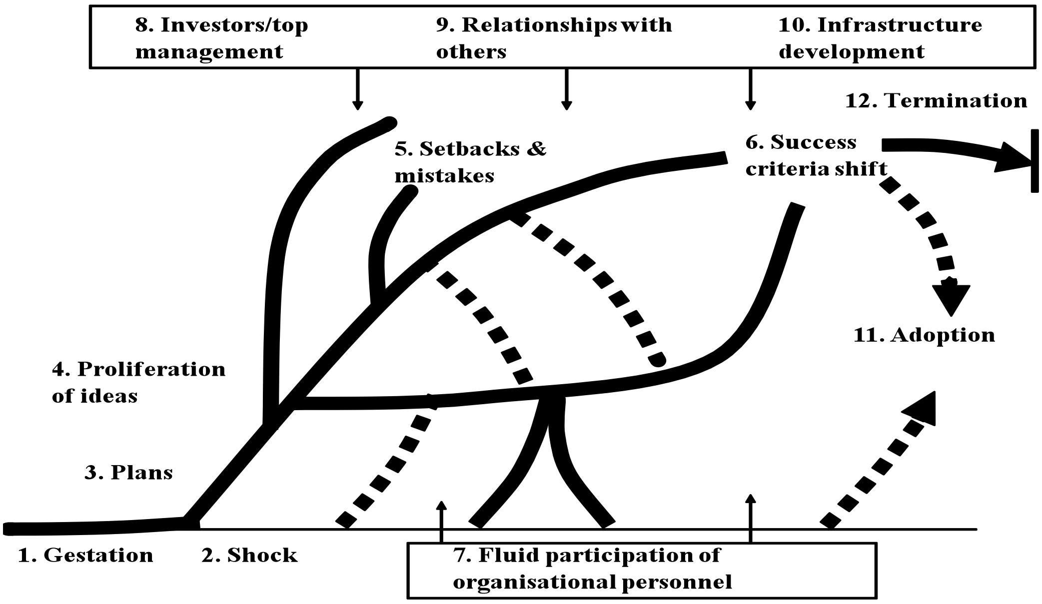
originating groups was instrumental in not only the initiation stage of the journey but also in keeping the momentum of the journey going.

4.2. The Innovation journey

The complex and diverse field of innovation has been addressed analytically by disciplines ranging from social anthropology to political sciences. Researchers have examined innovation from various levels including the service level, focusing on front line workers and their supporting organization through to government level, focusing on the politicians and institutions involved in overall policy developments at the national levels. At the policy level institutions can have a profound effect on the innovation taking place at the service level. Policy affects concrete actions such as regulations and funding through to support and encouragement for the innovation. Studying innovation at and for the policy level is in its own right important for numerous reasons; one in particular is that innovations at this level ultimately manipulate service level organizations (Rogers, 1995; Van de Ven et al., 1999). However, the focus of this study is the grass roots implementation of JON's innovation, not whether or not an innovation journey occurred within the NHS whilst developing intermediate care as part of a national service level of care. Consequently, all sources of innovation and behavioural change have been analysed from the perspective of JON, while being mindful that JON is part of, and influenced by, a greater social system.

Van de Ven and colleagues' (1999) prolific studies on innovation in business and the innovation journey compared a number of theoretical models in order to present an empirically grounded map of how innovations develop. Their findings suggest that the journey is divergent and paths numerous, preventing an orderly sequence. Accordingly they developed a complex, looping process model to map the innovation system events. The adapted model of this journey is presented in Figure 4.1.

Figure 4.1 Innovation journey



(Van de Ven *et al*, 1999: 25)

Scholarly research and real world private and public sector innovations were combined to produce this model which is used to describe the journey that organizations undergo in putting a concept into practice. This innovation journey model was the result of seventeen years of research with the Minnesota Innovation Research Programme (MIRP) into how and why innovations develop over time from concept to implementation. Van de Ven and colleagues have produced a uniquely valuable resource which facilitates the understanding of the process of innovation, specifically, how and why innovations emerge, develop, grow and terminate. According to the authors (1999) this generic innovation model is specific to innovation which:

> a) consists of a purposeful concentrated effort to develop and implement a novel idea;
>
> b) has a substantial technical and organizational market uncertainty;
>
> c) entails a collective effort of considerable duration;
>
> d) requires greater resources than those that are held by the people undertaking the effort (p. 22).

One could argue that intermediate care is not a novel approach to care and thus would not fit the criteria for an innovation journey. However, this argument is countered by Van de Ven et al. (1999) who state that an innovation need not be a new idea. It may be a reconfiguring of old ideas or a unique approach that is perceived as new to the individuals involved. The model of intermediate care being implemented at JON was considered by all parties involved to be a new model of care that sought to implement intermediate care within a nursing home complex. Van de Ven et al.'s (1999) innovation journey accurately captures what was happening at JON as they attempted to craft their own unique model of PCIC. Both the innovation journey model and JON's model of care refer to real time events; as such the innovation journey (IJ) model was used to frame the findings which are presented in a chronological manner in this chapter. The journey JON underwent is also superimposed on Van de Ven et al.'s (1999) model as seen in Figure 4.2

The innovation journey is broken down into twelve common elements that are clustered into four periods: initiation, developmental, implementation and termination. The following chapter focuses on describing these periods whilst simultaneously illustrating how the qualitative findings of this study depict a practical example of this innovation journey. The following are the common elements to this journey interwoven with the data collected throughout the study. At this juncture, it is important to acknowledge that according to Van de Ven et al. (1999) every process characteristic does not necessarily apply to all innovations.

4.2.1. The initiation period

The following are the common elements of the initiation period.

1. Innovations are not initiated on the spur of the moment by a single dramatic incident or by a single entrepreneur. In most cases, there was an extended gestation period lasting several years in which seemingly coincidental events occurred that preceded and set the stage for the initiation of innovations.

2. Concentrated efforts at initiation are triggered by 'shock' from sources internal and external to the organization.

3. Plans are developed and submitted to resource controllers to obtain the resources needed to launch innovation development. In most cases, the plans served more as ‘sales vehicles’ than as realistic scenarios of innovation development.

During JON’s initiation period several factors occurred. Privately, the JON Foundation as an organization was looking to open a new nursing home facility for older people. The facility would provide a total care living concept, enabling very frail people to live independently in their own home with any nursing care, personal care and other services brought to them if and whenever they were needed, ultimately reversing the conventional principle of moving the individual to where the care was being delivered and instead providing care in people's own home, which would be located on a care complex. This complex would provide suitable independent housing which would be supported by a care resource centre and other essential support services (personal correspondence, CEO, 2007). Concurrently, at a national level, the Government through the NHS plan and National Service Framework for Older People was focusing on developing intermediate care as a nationwide service. Locally, the PCT was undergoing changes as they strived to create pathways of care that would ensure the right treatment was available to the population as close to their home as possible and delivered by the most appropriate health care professionals.

Previously, in the geographical area where JON was situated, multidisciplinary rehabilitation services for older people occurred in a community based hospital. The buildings that comprised this community hospital did not lend themselves easily or cost effectively to reconfiguration in order to provide the new integrated and efficient services that the local PCT was proposing. As a result, the community hospital was closed down citing outdated infrastructure. The patients and staff were temporarily relocated to a local hospital unit and the PCT guaranteed the re-provision of services in this catchment area. The closing down of this community hospital was the shock that set JON’s innovation process in motion (see figure 4.2).

Of utmost importance to the gestation period of the innovation journey is the shock. Shocks serve to concentrate attention and the efforts of the members within the organization. Routines and complacency act against the forces that trigger shocks (Angle, 1989). Van de Ven (1986) describes this in cognitive terms by stating that people tend not to think about actions they do on a regular basis. Not all innovations get off the ground at this stage as they lack the shock needed to get the organization to act on the innovation. As Schroeder et al. (1989) explain a shock is ‘a major change in the organization or its environment’ (p. 123). A shock can take many forms (e.g. a new manager, a new venture) but regardless of its specific nature, a shock acts as a catalyst to stimulate the initiation phase of the innovation journey. In this particular case, the shock was the closing down of the old community hospital and the Government's promise to 're-provide' the care elsewhere.

During this time of gestation, Van de Ven et al. (1999) point out that 'chance plays a significant role in launching an innovation journey' and because of this the innovation journey could launch at any given time (p. 28). Moreover, during the gestation period various individuals engage in a variety of activities that set the stage for innovation. For JON these activities centred on a community hospital closing, the JON foundation looking to open up a new facility within a certain geographical area in the UK, the local PCT looking for new accommodations within that same geographical area, and the launch of intermediate care by the NHS.

After years of negotiating, a contract was entered into between the local PCT, social services, the JON Foundation and the local Acute Trust. This contract stipulated that, within the new JON Foundation nursing home complex, there would be a unit that would provide intermediate care to service users within the same catchment area as the previous community hospital. As part of the contract between the Acute Trust, the local PCT, social services and JON, JON would provide landlord services for the local PCT and the two social workers from the social services department (i.e. the local PCT would be located within JON's larger facility). The PCT and social workers would in turn provide the unit with the necessary therapist and social workers. The staff who were previously employed at the former community hospital and were then working at a local hospital on a rehabilitation unit, would be offered employment at JON under their current employment conditions for a two year period. Following this time JON was free to reassess these employment packages (wages, retirement packages, sick days, et cetera) and adjust as they saw fit. Thus, JON's intermediate care unit was born.

4.2.2. The developmental period

The following are the common elements of the developmental period.

4. When developmental activities begin, the initial innovative idea soon proliferates into numerous ideas and activities that proceed in divergent, parallel and convergent paths of development.

5. Setbacks and mistakes are frequently encountered because plans go awry or unanticipated environmental events significantly alter the basic assumption of the innovation. As setbacks occur, resources and development time lines diverge. Initially, resources and schedule adjustments are made and provide a ‘grace’ period for adapting the innovation. But, with time, unattended problems often ‘snowball’ into vicious cycles.

6. To compound the problems, criteria of success and failure often change, differ between resource controllers and innovation managers, and diverge over time, often triggering power struggles between insiders and outsiders.

7. Innovation personnel participate in highly fluid ways. They tend to be involved on a part-time basis, have high turnover rates, and experience euphoria in the beginning, frustration and pain in the middle period and closure at the end of the innovation journey. These changing human emotions represent some of the most ‘gut-wrenching’ experiences for innovation participants and managers.

8. Investors and top managers are frequently involved throughout the development process and perform contrasting roles that serve as checks and balances on one another. In no cases were significant innovation development problems solved without intervention from top managers or investors.

9. Innovation development entails developing relationships with other organizations. These relationships lock innovation units into specific courses of action that often result in unintended consequences.

10. Innovation participants are often involved with competitors, trade associations and government agencies to create an industry or community infrastructure to support the development and implementation of their innovations.

4.2.3. The implementation/ termination period

The following are the common elements of the implementation/termination period.

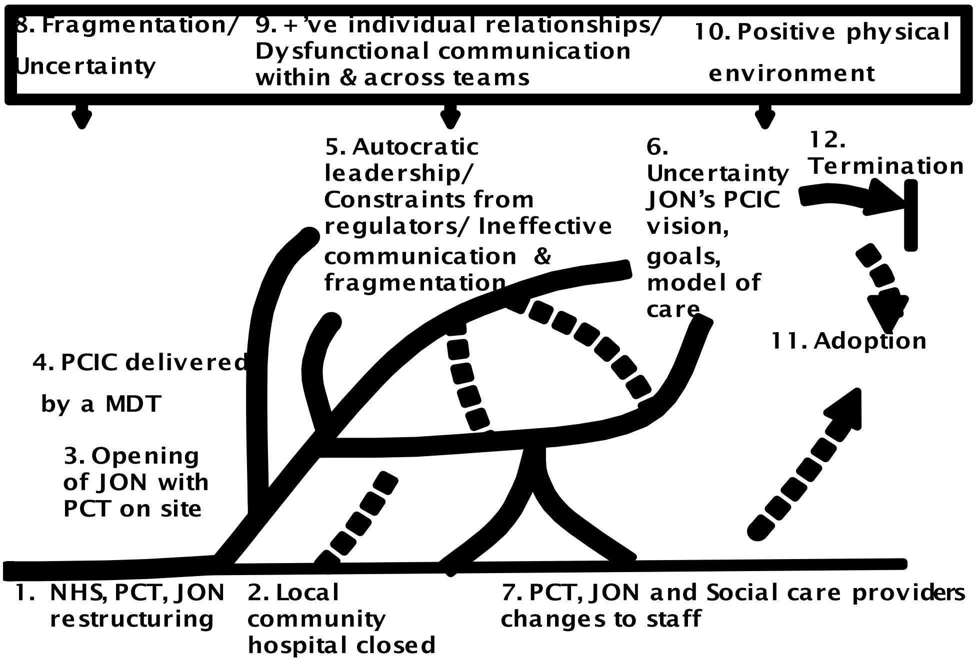
11. Innovation adaptation and implementation occurs throughout the developmental period by linking and integrating the ‘new’ with the ‘old’ or by reinventing the innovation to fit the local situation.

12. Innovations stop when implementation or resources run out. Investors or top managers make attributions about innovation success or failure. These attributions are often misdirected but significantly influence the fate of innovations and the careers of innovation participants.

(Adapted from Van De Ven et al., 1999, ch 2)

Figure 4.2 summarises, as a diagrammatic representation, JON’s innovation journey as experienced by the staff at JON, superimposed on Van de Ven et al.’s (1999) model. This will be discussed further as this chapter progresses.

Figure 4.2 JON's innovation journey



Adapted from Van de Ven et al., 1999, p. 25

Although figures 4.1 and 4.2 neatly represent the innovation journey, according to Van de Ven et al. (1999), and as experienced by JON, an IJ can be messy and complex and is a ‘non linear cycle of divergent and convergent activities that may repeat over time and at different organizational levels’ (p. 184). Divergent activities consist of those behaviours which involve exploring and expanding in different directions. Conversely, convergent behaviours lead to integration and narrowing, and focus on testing and exploiting a specific direction. Due to the complexity of the IJ it can be difficult to separate out various stages of the journey, as Van de Ven et al. (1999) have done when listing the common elements of the IJ process (p. 23). In fact, Van de Ven et al. (1999) themselves state that the implementation period of the journey occurs during the developmental period, marked by the adoption and implementation of the innovation by means of a constant linking of ‘old’ and ‘new’ in order to mould the innovation to fit the current situation (p. 54). Given the nature of this study’s findings, it was easy to separate out the innovation period of JON’s journey. However, JON’s developmental and implementation/termination periods are interwoven throughout the staff’s interviews and as such are presented alongside the staff’s qualitative themes in section 4.5 in order to expose JON’s innovation journey.

4.3. JON's innovative person-centred intermediate care model

This section of the chapter centres on JON's innovation journey with the purpose of describing the facility involved and the front line people charged with delivering the care. The JON Foundation sought to provide intermediate care within their new purpose-built nursing home facility by partnering with health and social care professionals to form a multidisciplinary team (MDT). Their approach to care amalgamated the NSF's (DH 2001) Standard Two: Person-Centred Care, with Standard Three: Intermediate Care (see section 6.6. for more detail on the NSF's standards). Combining these standards enabled JON to integrate commissioning arrangements whilst merging the not-for-profit sector with services from social care and health care, in order to provide person-centred care to older patients. Simultaneously, it focussed on delivering a single assessment rehabilitation service that assisted people from the local communities to:

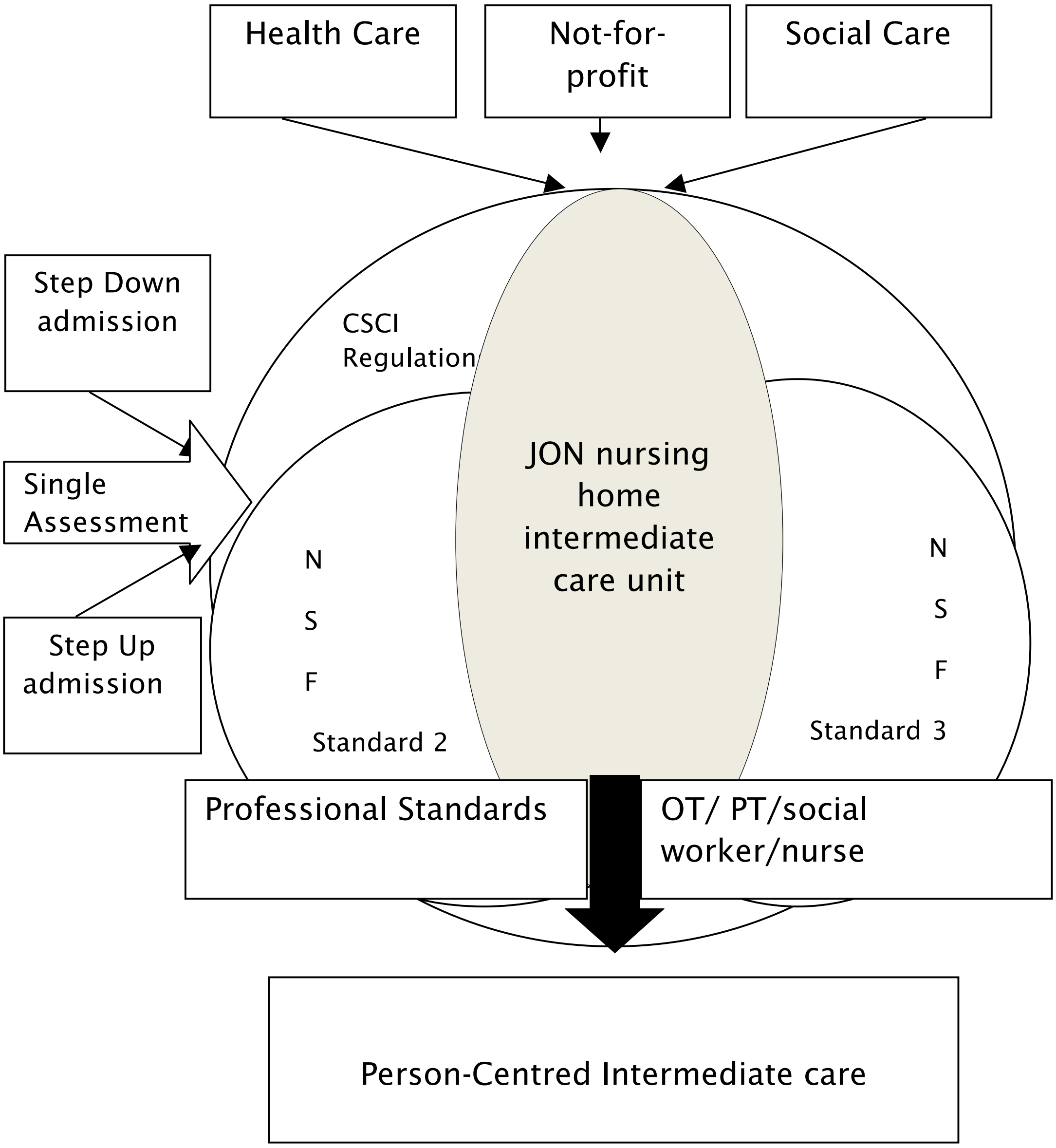
a) avoid unnecessary hospital admissions by being admitted via a step up admission

b) reduce their unnecessarily long hospital stays by accepting step down referrals and/or

c) avoid unnecessary or premature admission to residential care by admitting both step up and step down referrals.

Figure 4.3 illustrates JON’s PCIC model.

Figure 4.3 JON’s person-centred intermediate care model



Within this MDT, some of the health and social care professionals had a previous working relationship, whereas, others had not worked together but had worked under CSCI regulations, in other nursing home settings. In addition, a few of the staff members, crossing all three sectors, had worked on nursing-led hospital based rehabilitation units. This resulted in some members of JON’s MDT being keenly aware of how to provide short stay rehabilitation therapy. Some of the other staff, having been previously employed within the nursing home sector, were well versed in CSCI policies and procedures. When these three groups of professionals came together under one roof to provided IC with a strong rehabilitation ethos, in a facility whose ethos was person-centred care, staff and service user were catapulted into a journey that had not been anticipated.

According to the interviews undertaken with this study's sample, the proliferation of the staff's ideas concerning how to implement PCIC as a MDT with varied professional backgrounds and experiences led to many setbacks and mistakes. This ultimately resulted in an alteration of the basic assumption of this innovation (see section 4.6.). The participants' initial assumption was that the merger of three sectors would be, although challenging, an innovative approach to intermediate care. However, it quickly became apparent, through their narratives, that the most challenging and innovative aspect of JON was not the amalgamation of the three groups. The innovation was the unit providing short stay rehabilitation focused intermediate care, whilst adhering to long term, person-centred care regulations.

4.4. The JON Facility

4.4.1. Physical layout of the intermediate care unit

JON is owned and operated by the JON Foundation, a not-for-profit charity that was established in England to provide high quality services to meet the changing and individual needs of frail older people. JON is one of several care facilities that the organization operates for physically and mentally frail older people. The intermediate care unit is a purpose built 20-bed unit located within the larger JON complex that contains private sheltered housing and domiciliary care. As the 20-bed unit, not the complex as a whole, was the focus of this study it is the focus of this description.

JON complex is located in a residential area with easy access to local facilities. At the centre of the complex is the 'episodic care' unit. This unit is comprised of twenty single en-suite bedrooms that provide intermediate and respite care. Seventeen of these twenty beds are dedicated intermediate care beds that are commissioned by the NHS for two local Primary Care Trusts (PCT and PCT2) to provide care for members of the local community. The remaining three beds are used for private respite patients. The seventeen intermediate care beds were divided up into two groups; fourteen beds were designated to go to one local PCT (this was the primary PCT that was located on site) and the remaining three to another local PCT2. At the beginning of data collection the PCT2 assumed responsibility for therapy of the service users admitted into these three beds. This changed as the study progressed and is discussed in detail in chapter 4.

The intermediate care unit at JON was built in order to enable patients to recover from serious illness or operations nearer to their homes in a non-hospital environment. This quieter setting was designed to be more like a home environment with greater opportunities to socialize in communal areas such as the dining room and living room. Each service user benefits from a private en-suite room, television and radio and direct access to a patio area outside; service users can also have personal laundry done. All service users are outfitted with a wristband containing a nurse call button that is linked to pagers worn by nursing and care staff. Various activities and entertainment, such as visiting schools, choirs and a library with Internet facilities, are available to both the service users on the unit and the residents of the adjoining flats and bungalows. Other communal facilities located on site included a dining room, lounge, a shared communal garden and a rehabilitation gym. Other services within the complex consist of a coffee shop/restaurant, shop, hairdressers and chiropodist.

Although a designated intermediate care facility, according to the legal contract entered into with the JON Foundation and the NHS the unit is officially registered as a nursing home. The unit is therefore subject to inspection by the Care Quality Commission (CSCI, 2006), formally known as the Commission for Social Care inspection (CSCI).

4.4.2. Care of service users

It is held by upper management and clearly documented in the organization's policies, that JON valued the importance of maintaining service users' independence, and aimed to increase the opportunity for choice in all aspects of their care. This is done by having staff retain flexibility in the routines of daily living and respecting individual, unusual and eccentric behaviour from service users. Service users are involved in drawing up their plan of care, both prior to admission and throughout their stay. The facility has an open access policy regarding care records and all service users are a) to be consulted when plans are reviewed for changing needs and b) notified if there are any changes to their care plan. It is further recognized as a standard practice that the Unit Manager would be available, at any time, to discuss issues or problems with care. All service users and staff are to be clearly aware of the complaints process should any situation arise that needs to be addressed.

4.4.3. Staffing

A centre manager administers the overall JON complex, with the intermediate care unit being managed by a separate unit manager. At the time of the study, JON employed the nursing and auxiliary staff members. The PCT, social services and local Health Care Trust supplied the medical staff (consultant and SHO) and other members of the multidisciplinary team (MDT), specifically: 1 physiotherapist, 1 occupational therapist, 1 therapy assistant and 2 social workers. Both physiotherapist and occupation therapist have eighteen working hours dedicated to the unit per week. Initially, the therapy assistant was allocated to work on the unit for 4-5 hours per week. This number of dedicated working hours on the unit increased incrementally over the year of data collection to a total of eighteen hours per week. At the beginning of data collection, the physiotherapist and occupational therapist were charged with providing therapy for only the fourteen beds that were designated for the PCT located on site. The other three beds assigned to PCT2 received therapy care from an outside therapist working for PCT2. In January 2008 this changed when both the on- site physiotherapist and occupational therapist were charged with providing therapy to all seventeen beds. The therapists' dedicated working hours on the unit did not change with this increase in workload.

The therapy assistant's hours did, however, increase several times until at the end of data collection the assistant's hours had reached an equivalent of three days per week. The medical input provided to the unit was done under the responsibility of a hospital consultant in gerontology and senior house officers (SHO). The SHO was on site two full days and two half days per week. The consultant and the SHO were part of the weekly MDT meetings and out-of-hours advice was available from the on-call medical team located at the local hospital and from local GPs.

The nursing care on the unit was provided by qualified nurses and care assistants who came from a variety of backgrounds. A large proportion of this staff transferred directly from the local community based hospital that had been closed down and relocated to a local hospital ward. This group of individuals were used to working with a MDT and coordinating admissions and discharges, but within the support of a hospital environment. Others came from employment in nursing homes, so were more comfortable without medical back up but less used to the high through-put of service users. The Unit Manager came from a background of working in the community for a Preventing Dependency Team and thus viewed the running of the facility from a community angle and less like a hospital.

Based at the same site as the intermediate care unit was the local PCT's community Rehabilitation Team. This team was comprised of nurses, physiotherapists, occupational therapists and therapy assistants working in the community to provide both rapid response and short term support and rehabilitation to individuals in their home. This team referred service users to the unit as step up admissions. In conjunction with the PCT located on site, the following health care professionals were available to the service users via referral: dietician, speech and language therapist, optician, dentist, chiropodist, audiologist, local PCT rehabilitation team – as per referral for ongoing rehabilitation needs when returning home.

Each service user had two named nurses in charge of coordinating their care. As such the staffing schedule (known at JON as staff rota) was set out in a manner that enabled the named nurses to maintain continuity by placing them on duty at different times, thus, ensuring the residents received continuing input from a named qualified nurse. This structure for the allocation of care changed several times during the data collection phase. The instability of the work schedule was a key element of concern for the staff (see section 4.6.1.5.(3)).

4.4.4. Referrals

The three respite care beds on the unit were purely for private referrals at a cost of £115.00 per night. Conversely, the intermediate care beds which were NHS funded, received referrals from the local hospitals' acute trusts, GPs and the above-mentioned Rapid Response Team. Placements for the IC beds were limited to the period of rehabilitation, which was meant to be no longer than six weeks, whereas, admissions to the respite care beds occurred if there were bed vacancies and the care needs could be met. These respite care beds did not follow the same guidelines, objectives or aims as the intermediate care beds and thus, the service users occupying these beds were excluded from the study.

4.4.5. Admission Policy

In accordance with the terms of the Agreement entered into by the JON Foundation, and the NHS, the service users entering the unit were NHS funded and admission to the intermediate care unit was restricted to the following:

- Step down – to facilitate discharge from acute hospital care as part of a planned rehabilitation and hospital discharge process;

- Step up – direct to the intermediate care unit from the service user's normal place of residence as part of a crisis intervention plan;

- Crisis/emergency admission– this was subject to a) bed availability on the unit when the service user fitted the admission criteria and b) an admission to acute care could be avoided. The PCT's Transfer of Care (TOC) team coordinated bed management/availability in close liaison with the unit manager.

The transfer of care was from a hospital ward, a local Accident and Emergency Department or from the community. In all cases a recent change to the service user's condition was essential.

As part of the facility's mandate a comprehensive pre-admission assessment was carried out by the GP or TOC team who was responsible for making the referral. This guideline was instituted by the facility as a means of determining if the prospective needs of the service user (physical, mental, social and spiritual) could be met by the unit. Once a care management needs assessment was complete the referring body would contact JON. The Unit Manager or the designated deputy on duty would discuss the service user's needs and agree upon (or not) an admission. The following is a list of criteria for admission to the unit:

- service user had to be over 65, although those over 55 were considered on merit (no more than five service users aged 55–65 were allowed to be admitted to the unit at any given point in time. Remainder of the unit's beds needed to be occupied by service users 65+);

- on the referral form clear rehabilitation goals and length of stay were to have been identified and agreed to by the service user (this part of the form was not always completed, see section 5.2.2.5.);

- estimated length of stay (ELS) on the unit was to be less than six weeks;

- service user would not exceed the Level 4 Criteria of Care.

4.4.6. Service user documentation

Upon admission to the unit a JON chart, nursing kardex and care plan were generated for each service user and remained on the unit for the duration of the service user's stay. The structure and location of these records changed several times during the data collection phase. However, by the end of data collection (July 2008) the following protocol was in place. The nurses and care assistants recorded their notes in the nursing kardex (which was kept at the nurses' station) or in the patient care plan (which was kept in the service user's room). As a means of facilitating the sharing of information the physiotherapist, occupational therapist, social workers and physician recorded a limited amount of information in the nursing kardex. The majority of their documentation was kept elsewhere in the chart.

Following discharge, the medical notes were returned to the local trust where the service user's stay was recorded by the hospital coders. The remaining chart was archived on site. The charting system followed CSCI regulations and was developed with long term residents in mind. This meant that areas such as patient updates and evaluation of goals set were to be completed monthly, rather than on daily or weekly bases. The nursing home focus of the charting system caused great concern for the staff, who were functioning in a short term, quick through-put manner.

There were many concerns voiced over information getting missed as there was no common multidisciplinary sheet in which all members of the MDT recorded information such as changes to the rehabilitation plan, suggestions or progress. Each member of the MDT recorded in their specific section of the chart, for example, the Doctor wrote in the medical section, physiotherapists and occupational therapists in the therapist section and nurses in the progress section.. Furthermore, the carer did not record in the main chart at all (see section 4.6.2.1.(c)).

4.4.7. Information packages

Upon admission to the unit, each service user was to be given a welcome package. These packages consisted of a description of the JON Foundation as an organization, JON as an intermediate unit, appropriate information on the unit's complaints, fire and emergency procedures. Along with this information, part of the welcome package contained a form that had the following information:

- Your name
- Planned discharge date
- Named nurse
- Unit manager
- Physiotherapist
- Occupational therapist
- Social worker
- Consultant/Doctor
- Other staff names

The data presented in this section were derived from data routinely held on the unit. The following section focuses on the data obtained by interviewing members of the MDT to ascertain what was occurring on the unit throughout the data collection period. The data that emerged from the interviews highlight the successes, setbacks, mistakes, the fluid participation of staff and the challenges of merging old with new as the staff travelled through their innovation journey.

4.5. Staff interviews

Post-interview summaries and the transcription of all interviews followed the study's design protocol without fault. The data from the interviews were transcribed then broken down and analyzed in order to reveal underlying, tacit social order and units of meaning. Early interviews, randomly selected subsequent interviews and themes were reviewed with one of the study's supervisors and the themes discussed. As intended, these themes along with the Balanced Scorecards (see Appendices 11 & 12) shaped the formative feedback (see section 3.6.) that was provided intermittently for the JON staff. Appendix 2 provides a detailed account of the formative feedback process and how the staff used this information throughout the life of the study. The JON Foundation (management, the study's steering committee, and informants) also received this feedback; however, their comments did not become part of the data collection as the staff comments did. The feedback to the JON foundation was done in order to ensure the foundation was kept apprised of the working on the unit should a situation need to be addressed from a management standpoint.[2]

4.5.1. First interview session

The first set of staff interviews generated five themes, each having several sub-categories. These themes are illustrated in Figure 4.4. and a detailed explanation of each follows.

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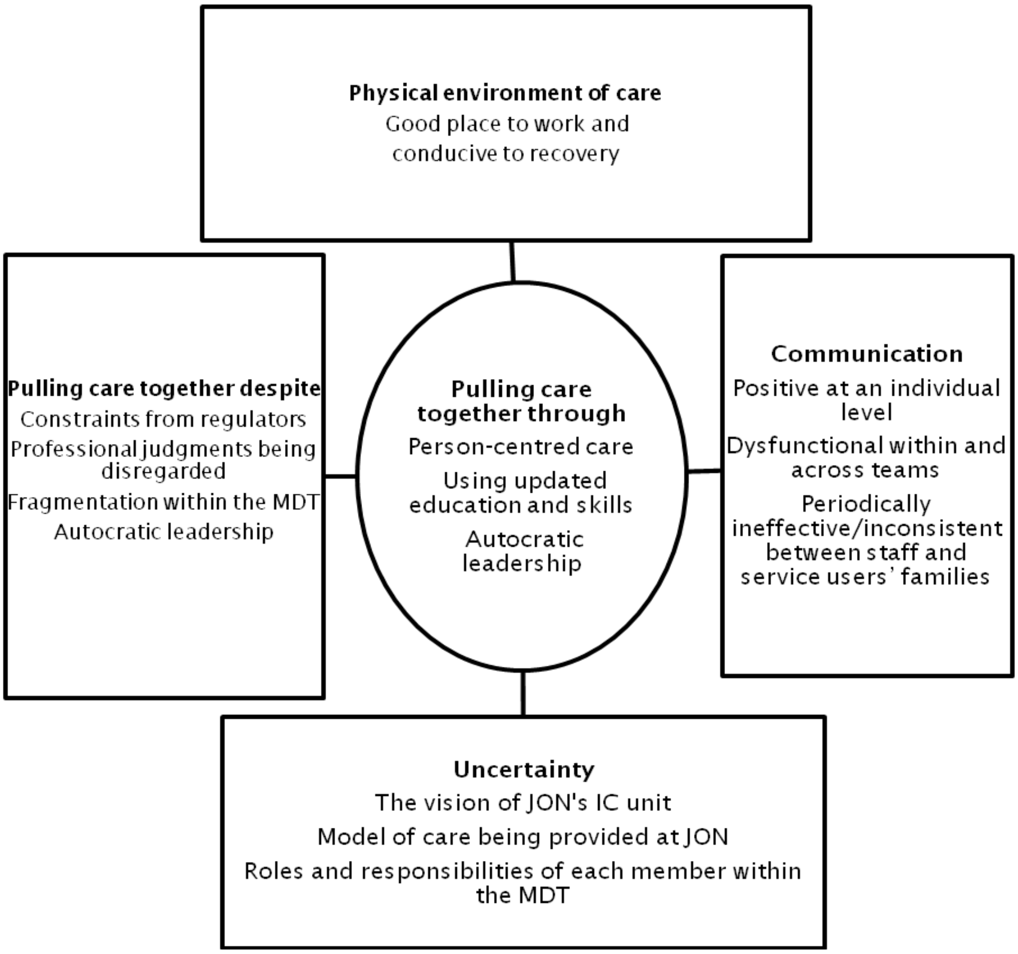
[2] Such was the case when comments focusing on autocratic leadership and bullying were brought up in the staff interviews. To ensure safety of all practising on this unit this information was presented to the study's steering committee (made up of some of the JON foundation's top executives). Anonymity of the participants was maintained.

Figure 4.4 First set of staff themes



4.5.1.1. Pulling care together through …

As figure 4.4 illustrates, the central theme identified from the initial set of staff interviews focused on staff providing their own form of intermediate care by 1) employing a person-centred approach to care (DH, 2001; Nolan et al., 2004; SCIE, 2010) utilizing recent updated education and skills; and 3) making the most of the autocratic leadership that was driving the unit.

1) Person-centred care

All government funded nursing homes, within the NHS, who are regulated by CSCI, adhere to the National Service Framework for Older People's Standard Two: Person-centred care. Within JON (which is a registered nursing home), one of the core philosophies focused on caring for older people with dignity and respect by staff who appreciate the older person's need for privacy, individuality and freedom of choice. The staff at JON were aware of this philosophy. When asked what model of intermediate care was being implemented on the unit, the majority of the staff could not articulate a specific IC model; rather, staff were keenly aware they were providing person-centred care.
This ethos with JON is about [a] person-centred approach.

Identification code 111

They have their rights…it is very important and they have their own choice. [Staff] are aware of this person centredness.

Identification code 501

2) Using updated education and skills

Staff expressed pride and pleasure in attending new educational sessions and implementing new skills on the unit. Nine out of twelve care assistants on the unit had attained National Vocational Qualification in care level two or above or were studying for the qualification. All staff (qualified and care assistants) attended mandatory fire safety, health and safety, moving and handling and first-aid training courses. Other educational sessions provided were, medication awareness, diabetes education, food hygiene training, infection control courses and Contamination of Substances Hazardous to Health (COSHH) courses. The physiotherapist on the unit also provided informal educational information sessions to staff on anatomy, moving, and positioning and relevant rehabilitation exercises.
I've done a lot of training really.

Identification code 501

We got some training... it has been provided by our company.

Identification code 83

3) Autocratic leadership

From the onset of the interviews, there was a great deal of discussion that focused on the autocratic style of leadership prevalent on the unit. Although this style of leadership caused grave concern for the majority of the staff, comments such as the following indicate that some staff utilized this form of unwavering management to their benefit. When a local Transfer of Care (TOC) team was attempting to admit a service user, who was inappropriate by JON admission standards, a staff member commented:

I just told them, I don't have the authority to say yes or no, you'll have to call back on Monday.

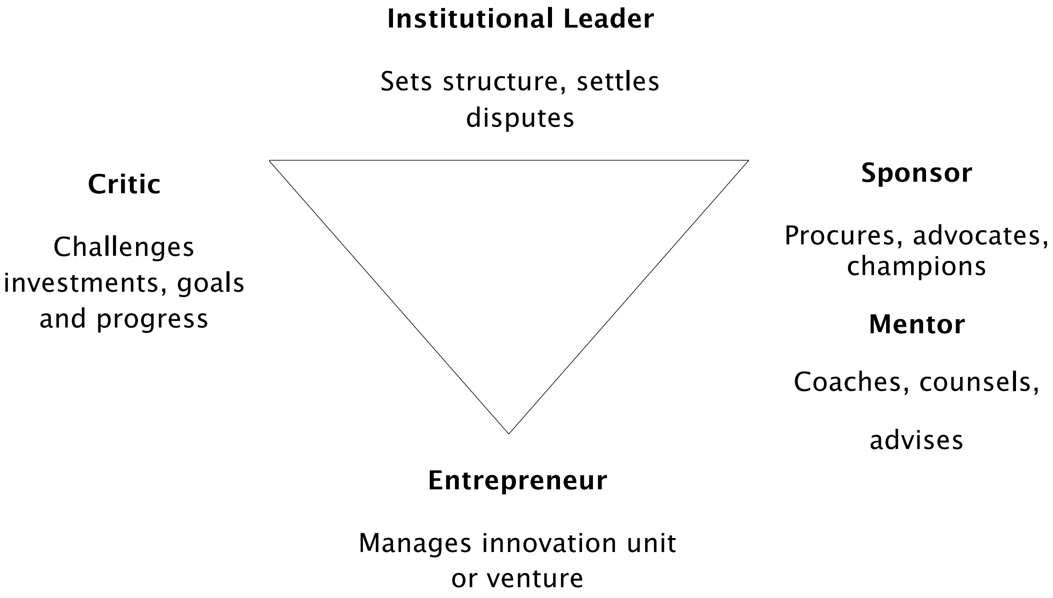
Identification code 112

The person gets a lot of the say and sometimes that is not a bad thing... Has pushed for there to be two registered nurses on and now there is.

Identification code 111

According to Van de Ven et al. (1999) within an innovation journey, top managers at different levels in the organizational hierarchies do not unanimously reflect a unified perspective. Rather they differ in their views and often perform tasks that act as checks and balances for the other leaders in directing the innovation participants. The roles assumed by managers are 'mentor, critic, corporate sponsor and institutional leader' (p. 98) (see figure 4.5).

Figure 4.5 Leadership roles



Adapted from Angle and Van de Ven 1989 p. 681

Every force in a social system has an equal and reactive force. This is also true for the leadership roles played within an innovation journey (as depicted in the triangular shape used in Figure 4.5). The sponsor and mentor roles provide the checks and balances for the critic role, whereas the institutional role is usually assumed by an executive who is removed from the direct daily activities and therefore, less subjective. This role works to maintain a balance between the pro-innovation sponsor and the ‘reality-testing’ influences of the mentor (p. 100). The person assuming the institutional role is an individual for whom the innovation is just one of their responsibilities and this psychological distance affords them the perspective of a person who is involved, yet removed from the front line, a perspective that is not available to those ‘in the trenches’. In this case study, during the time of data collection, the Centre Manager held this role. In the trench is the entrepreneur, whose only role is the innovation. At JON, the Unit Manager filled this role.

These leadership roles can be taken on by more than one person at a time. People within the organization may assume a different role at a different time. All roles play an important part in the innovation journey. It is when an opposing role is not being filled that the situation can become unbalanced. A practical example of the unbalance that can result from a vacant role was seen at JON. The critic role was being assumed by the Unit Manager and those who originally assumed the sponsor and mentor roles had been relocated due to organizational restructuring. This resulted in the counterbalancing roles of mentor/sponsor being left empty. As seen in Figure 4.4 the critic role is performed by a 'devil's advocate who takes dispassionate hard-nose business criteria' approach to the innovation (Van de Ven et al., 1999, p. 99). This critic role is usually balanced by the mentor and sponsor roles that are pro-innovation and as such, advocate, procure, coach and counsel.

Across various innovations, Angle and Van de Ven (1989) noted that innovations encountered significant difficulties and challenges when one or more of the leadership roles was not being filled. Within JON's MDT, this appeared to be the situation with the loss of some of the original leaders who had been identified by staff in the interviews as strong sponsors/mentors and supported or advocated for the front line workers. Without the counterbalance role of mentor being filled the critic was able to progress unchecked. According to the staff narratives this resulted in many setbacks and mistakes.

The theme, *Pulling care together through,* was fundamental to all the other themes that arose in the interview sessions and despite the concerns addressed in the other four themes the staff were still able to provide quality care. This mis-match between how the staff felt and the care they were providing is the focus of chapter 6 and is alluded to here in the following quote. This came at the end of an hour long interview in which the staff member continuously voiced concerns over the dysfunctional working of the unit:

But really something must be working right...from the amount of thank you cards.

Identification code 910

4.5.1.2. Pulling care together despite...

The second theme, *Pulling care together despite,* acknowledges the challenges that had to be overcome in order to provide quality care. These impediments have been clustered into four categories: 1) constraints from regulators, 2) professional judgments being disregarded, 3) fragmentation within the multidisciplinary team (MDT), and 4) autocratic leadership. The following is an explanation of each.

1) Constraints from regulators

JON was registered as a nursing home under the regulations of CSCI. Participants voiced safety concerns over JON wanting to function as an intermediate care facility, yet having to abide by nursing home regulatory requirements. Comments focused on the incompatibility between a long term care regulating body and a facility that was attempting to provide short term intermediate care. From the following quotes and many others it was evident that meeting the requirements of the regulatory body affected the amount of training that was offered, the form of charting used (designed for long term care facilities) and staffing levels.

CSCI don't have their head around that it's different...They [CSCI] really haven't got any experience of what we are doing...They are mainly long stay nursing homes so a lot of their training is geared towards the long stay residents. We're sort of out on our own to what training and development we need.

Identification code 83, 103 & 111

[We have] really heavy patients, but [a nursing home] always has the same number of staff, even if dependency is higher [at JON] there is no increase in staffing levels. That's what we were dealing with, it wasn't safe.

Identification code 101

As the latter quote suggests, the regulations set by CSCI had a profound effect on the team's ability to function as an intermediate care unit. From an IJ perspective, according to Van de Ven et al. (1999), there is a web of complex relationships between organizations involved in the innovation which has a profound effect on the innovation. As these parties interact and perform their varied tasks, they change the technical, institutional and economic characteristics of the innovation. The 'interorganizational relationships' become all consuming and monopolize a significant part of the journey for new individuals embarking on the venture (p. 126). JON's relationship with CSCI clearly demonstrated such an 'interorganizational relationship'.

Staffing became a safety concern around Christmas time when, due to bed pressures at the local hospitals, the unit accepted service users with greater dependency levels than that with which they had previously dealt. However, as the unit was functioning under a nursing home umbrella and the regulations that go with it, the staffing levels did not accommodate this increased level of dependency. Both the relationship with the referring bodies (e.g. having to rely on them to fill their beds) and with CSCI clearly illustrate how an outside organization(s) can alter an innovation's course of action and result in unintended consequences. Although CSCI did not cause the admission of service users with higher dependency levels, it did impede the unit from being staffed appropriately to accommodate these admissions. This had a ripple effect on staff morale and the functioning of the unit.

During the developmental phase of an IJ, as setbacks occur, resources and developmental time lines diverge and problems increasingly ignored can 'snowball'. According to staff the setback that occurred at Christmas resulted in 1) inappropriate admission of service users, 2) short staffing of the unit, and 3) the IC beds on the unit being occupied for longer than the stipulated six week period (in one case five months) by service users who were confused and unable to actively engage in a rehabilitation plan of treatment. These setbacks were not dealt with suitably and 'snowballed' into a vicious circle (see section 4.6.2.)

2) Professional judgments being disregarded

Within an IJ, power struggles can result from a blurring of the lines between various participants' criteria for success and failure (Van de Ven et al., 1999). At JON power struggles dominated the professional relationships on the unit and were evident in the narratives which focused on professional judgements being ignored within the MDT. The interview findings suggest that during the weekly MDT meetings decisions regarding the care for the service users were made and agreed upon by the team. Unknown by other MDT members, these decisions were subsequently altered by a member of the MDT who was assuming the critic role. The effect that this disregard for professional judgements had on staff's morale and workplace satisfaction is evident in the following quotes:

Decisions that are made in that meeting can be overruled out of the meeting. Overrule them without telling anybody, no communication. You don't actually get a specific reason why, I'm embarrassed it is unprofessional and it is wrong...ideas sort of get pushed aside whether they are good or not. Chips away at the service we are giving.

Identification code 140 & 111

3) Fragmentation within the MDT

At the beginning of an IJ, participants have been noted as experiencing euphoria followed by frustration and pain in the middle and closure when the journey ends. The changing human emotions that occur during the journey can be some of the most 'gut wrenching' experiences for participants and managers (Van de Ven et al., 1999). The emotional turbulence that the JON staff underwent was palpable during the interview sessions. During the first set of interviews, the participants' frustration and pain were beginning to show through. This emotional unrest became more concentrated during the second and third set of interviews and crossed all themes.

The loss of the sponsor and mentor role within JON had a profound effect on the team (Van de Ven et al., 1999). At the inception of JON's intermediate care unit there were four key members of the intermediate care team that were involved in the development of the unit from a practice standpoint. They were members of the JON Foundation, the PCT and social services. However, by the time the first set of interviews had been held two of the four members had gone on to other employment. This was causing an unequal representation of the PCT at the MDT meetings. Originally, the meetings were attended by the PCT and JON managers, the MD and SHO, a qualified nurse(s), the physiotherapist, the occupational therapist and one or both of the social workers. The dynamics of the MDT had been altered by the loss of the PCT's manager. The post remained open and therefore no management represented the PCT segment of the MDT. Although various members of the PCT continued to play an active role in the MDT, there were comments made that suggest the team was struggling to be supported.

The specialist doctor now attended the weekly meetings sporadically. Some members of the team credited the doctor with *'keeping us on track' (ID code 94)* and expressed a sense of loss with the doctor's decreased presence in the weekly meetings. It must be noted, however, that the senior house officer's attendance at the meetings did not fluctuate. The following quotes emphasise the unease with the inter-professional working relationships that was being experienced on the unit:

It all seems a bit of a power struggle. Our team needs to be integrated better the link is just not there...you are divided by who employs you.

Identification code 94 & 103

4) Autocratic leadership

During the interview sessions, it became apparent that staff were distressed over what they perceived to be an autocratic leader. Staff morale was reportedly low, and staffing numbers were showing this through a significant number of staff 'sick calls'. There was mention of being 'micro-managed' and having no 'nursing leadership' to support the staff. The following is an amalgamation of various staff comments that adequately summarize this category:

If you had a leader to motivate you and one who knew what was going on you would look towards your leader…the leadership from head office down is removing staff's autonomy...too much rigidity…we are being treated disrespectfully, we are professionals with professional opinions that are not being respected...I just hate working like this it is unsafe… tried to undermine our confidence as a team.

Identification code 103, 140 & 111

Of concern was the following comment:

Certainly people have been treated very badly here. They have been in tears, it is bullying really. There is a whistle-blowing policy here but that is just the way it is, no one is going to do anything about it, it wouldn't be taken seriously, it could just make it worse for whoever said things.

Identification code 108

4.5.1.3. Physical environment

1) Good place to work and conducive to recovery

On a positive note the physical environment of care, both on the unit and the facility as a whole, was deemed to be an encouraging feature of the service being provided by JON. The effect on staff and service users of this new unit, within an ultra-modern building, that contained new furnishings, equipment and bright, open spaces, is highlighted in this quote:

What's working is the environment...happy team because of the environment, which reflects on the residents...comfortable environment with nice facilities and surroundings motivates them.

Identification code 112, 111 & 83

4.5.1.4. Communication

Communication from both a positive and a negative aspect was the focus of much discussion.

1) Positive at an individual level

On an individual basis (practitioners/care assistants), the staff articulated a positive communication style with colleagues both within and across the various teams (JON, PCT & Social Services).

2) Dysfunctional within and across teams

There was concern expressed over the lack of communication that took place across teams such as, within the MDT, from hospital to JON and from JON to the PCT. The lack of communication between JON and local hospital(s) was highlighted several times during the course of the study when nine SUs had to be excluded from participating in the study as they were confused and disoriented to person, place and time. One of the admission criteria for the unit stipulated that prior to transfer the service users had to be competent and able to consent in writing to a treatment plan and estimated length of stay. According to management at JON, this admission criterion had been communicated to the Transfer of Care (TOC) teams at the hospital prior to the unit opening. From the narratives, it was concluded that the hospital(s) was providing misinformation or insufficient information to the unit; and service users who did not qualify for admission were being admitted to the unit. Concern over misinformation is further highlighted in this quote:

The reason why we are so hesitant to accept people is that the hospital doesn't always give an accurate description of what the service user is really like.

Identification code 112

Concern with a lack of communication with the care assistants was noted. The care assistants did not attend the weekly MDT but were said to be 'represented by the qualified nurses' (personal communication, Unit Manager, 2007). Furthermore, they did not attend the shift change 'turn-over meetings' in which a daily exchange of information focusing on the service users (their care plans, conditions and concerns) took place between the qualified nurses. This concern is highlighted in the following quote:

Handovers are very poor you're never sure whether things are communicated back and forth...the carers don't have a handover they go straight to work...the qualified get a handover at shift change but not the carers.

Identification code 801, 71 & 101

3) Periodically ineffective/inconsistent between staff and service users

This lack of communication extended to the service users and their families. When questioned who was responsible for communicating the weekly decisions made in the MDT to the service users, no one within the group of staff participants was able to identify the person charged with doing so. However, all respondents were adamant that it was not specifically their responsibility. According to the staff/informants narrative, although the nursing staff did communicate various aspect of the decisions back to the service user(s), there was no set process for this information exchange. The following extract exposes the consequences of this lack of communication:

It sounds like I am having a moan, but at the end of the day the patients are the ones that are suffering from this reluctance to work together.

Identification code 103

4.5.1.5 Uncertainty

This category illustrates how problems occurring in the IJ can be compounded by the reality that the criteria for success and failure often differ between resource controller and innovation managers (Van de Ven et al., 1999). This final theme draws attention to the uncertainty being experienced by staff on the unit. The qualitative findings exposed feelings of vagueness, insecurity and doubt over JON's vision of intermediate care, the IC model being implemented and the roles and responsibilities of all MDT members.

1) The vision of JON's intermediate care unit

The uncertainty over the vision and what the staff were meant to be doing on the unit is exposed in the following interview extracts:

A bit weary of working for a nursing home organization in the private sector, they've no perception on what it is we are trying to achieve...I just feel it's a rehab unit...it is very much like a nursing home...We are just doing what we did in the hospital...we have different employers and those employers have different aims...it is so inconsistent, tomorrow it may actually be different; I think it is very fuzzy.

Identification code 610, 71, 111 & 83

2) Model of care being provided at JON

Regarding the intermediate care model being used, the following quote stressed what the majority of the participants was expressing during the interview sessions:

I have never heard anything about a model...be nice if somebody could just say what they want us to do. What the model of care is and everything. I don't think there is a model; some of the nurses are going by what they did in hospital. People who worked in nursing homes are going by nursing home. No one really knows.

Identification code 101

3) Roles and responsibilities of each member within the MDT

Throughout the interviewing sessions, staff commented on the need to have a theoretical model of care which would provide greater guidance to the MDT. They also commented on the need for more educational sessions focusing on vision, practical examples of person-centred intermediate care, and role description and responsibilities on the unit, as well as displeasure with the autocratic leadership style dominating the unit. When questioned whose responsibility it was to address any of these issues, staff did not articulate any ownership for this task. The staff knew these areas needed to be addressed, yet lacked insight into who was responsible for doing so.

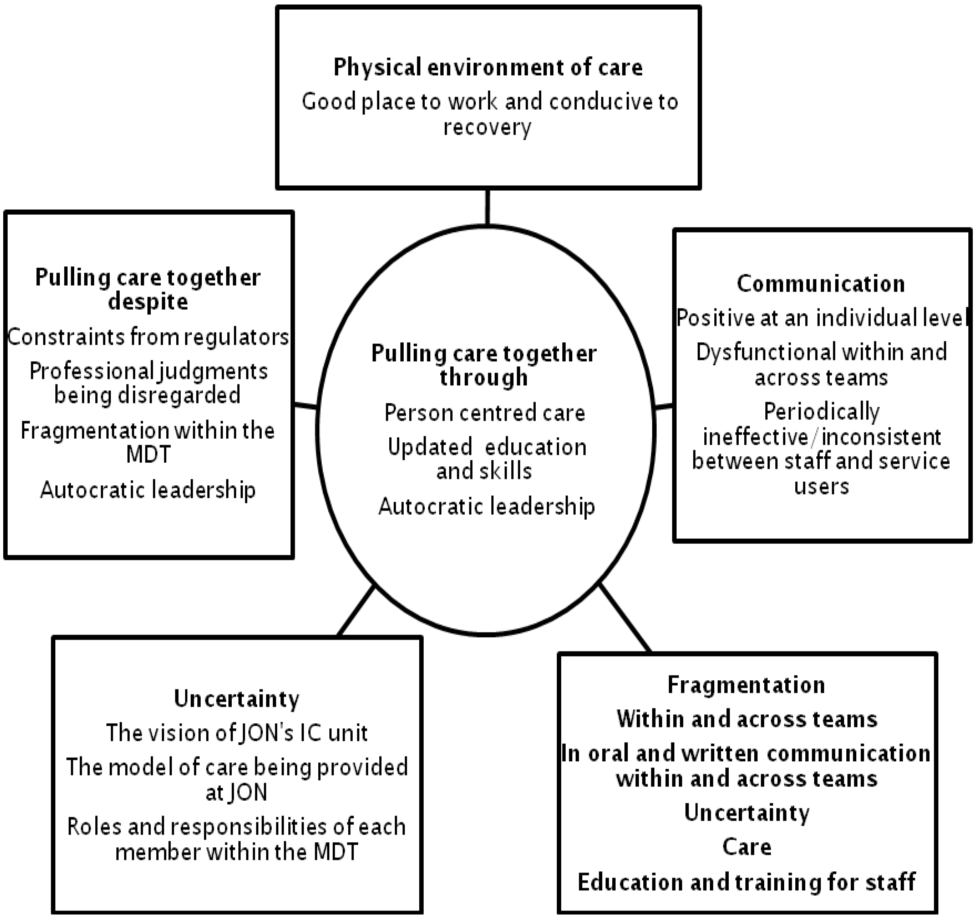
The staff's inability to take ownership to improve practice is not uncommon. The staff was searching for what Van de Ven et al. (1999) refer to as a 'hero leader' who could deal with all of their concerns and issues. During an IJ when setbacks and mistakes occur, it is common for front line workers to look outwards for a 'hero leader' to take the initiative and bring significant change. At JON, the staff's endless search for a heroic figure, that would come along and rescue the team, ultimately diverted the team's efforts from looking inward and evolving.

Another common occurrence within an IJ, and experienced by JON, is what Van de Ven et al. (1999) refer to as 'hung juries'. When equipment was needed for the unit, be it new equipment (e.g. chair lifts) or replacement of old equipment (e.g. broken wheelchairs) there was a lack of consensus as to who was responsible for purchasing it. During an IJ, a complex network of relationships exists between the various members involved in the innovation. Although the transactions that these various participants engage in are needed to push the innovation forward, they can also result in unintended consequences. One unintended consequence is the 'hung juries' in which parent organizations are unable to reach agreements on specific ways to share risks, costs or the pay offs of the innovation when they emerge (p. 51). Such was the case here when neither the PCT nor the JON foundation would assume responsibility for purchasing rehabilitation equipment.

4.5.2. Second interview session

Due to attrition the number of staff participating in the second phase of interviews dropped from twelve to nine; the loss of participants was due to changes in employment status rather than an unwillingness to take part in the study. The findings from the second set of interviews indicated that the areas of concern originally identified during the first interview sessions continued to be of concern. Additionally, a new theme focusing on the fragmentation of the unit emerged. As such figure 4.4 has been amended to include this theme in figure 4.5.

Figure 4.5 Second set of staff themes



Following the analysis of the second set of interviews it became apparent that problems and setbacks experienced by the participants were not resolved satisfactorily and as such began to ‘snowball’ into a fierce loop of negative actions and emotions. A sense of fragmentation cut across all other themes (thus the similarities between theme 6’s sub-categories and that of the other themes). The fragmentation dominating the unit was evident in all of the interviews and highlighted in the following comments:

We don’t really know where we stand...morale is low and we are going down quickly...I still enjoy what I am doing but it is very difficult place to work…Not only have things not improved they have gone down hill.

Identification code 610, 94 & 140

The first five themes identified in the second set of interviews remained unchanged from the initial data collection phase. As the narratives from these interviews contained similar comments to those already presented in this chapter, these themes will not be revisited. However, due to the serious implications arising from the sense of fragmentation on the unit, this theme is discussed in greater detail.

4.5.2.1. Fragmentation

1) Within and across teams

The in-house team (JON, PCT & Social Services) was seen to be either maintaining the status quo or slipping. Although both the first and second set of interviews were saturated with comments expressing the need for a team meeting to revisit the vision, aims and goals of the unit, no such meeting had occurred nor was scheduled. The only meetings open to all members of the intermediate care team over the year-long data collection period were the study's information sessions. Furthermore, the PCT leader had left the department, and the post remained vacant at the time of the second set of staff interviews. Additional staff and management changes within the PCT and Social Services meant that by February 2008 the unit had only 1 of the four key players (involved in the original development of the unit) left. Figure 4.2 illustrates how the fluid participation of participants spanned the journey and the comments made during all three sets of interviews highlighted the unrest that this caused.

Communication was always good with the PCT but now the leader has gone and no one to support [the PCT members] in the meetings.

Identification code 103

Attendance at the weekly MDT meetings had become inconsistent. A continued sense of lack of support and direction was evident.

I think there are various people in the MDT who think they are right and don't always want to listen to other people's opinions and there are other people who need a bit of dynamite to be more proactive in what they are meant to do. They have become a waste of time really.

Identification code 83

Outside JON, communication with the TOC team(s) from the local hospital(s) continued to be a challenge for staff working on the unit. The inappropriate referral of SUs was the subject of great debate. The chief complaint focused on education (or lack thereof) for all involved on what kind of facility JON was and what services were provided there. Specifically voiced was a need to overcome misconceptions by hospital staff that JON was a nursing home or private facility. Alternatively, there was concern voiced that the local transferring hospital(s) expected the unit to have the same access to medication stocks and transport to clinics or radiology as local hospitals had. It must be noted that although this miscommunication on the part of outside agencies persisted, since the inception of the unit there had been a TOC team in place at the two local hospitals to educate colleagues in secondary care about the unit's capabilities. Staff were showing signs of resigning themselves to the fact that this lack of understanding or miscommunication was not going to change anytime in the near future.

During an IJ, involvement with outside government agencies is needed to create an innovation organization infrastructure to sustain the innovation (Van de Ven et al., 1999). However, these relationships can often lead to unintended consequences. Such was the case between the local hospital trusts and the unit in regards to referrals. The unit was reliant on the trusts to fill their beds. However, the patients that were referred to the unit were not always deemed suitable by staff on the unit for intermediate care.

We can't admit blind people but no one told us they were blind until they got here. What were we to do send them back?

Identification code 111

Further concern over the 'seamless continuum of care', (DH, 1997c) which was a driving force for the development of IC within the NHS system, was noted and expressed succinctly in the following quote:

The service users should come here into intermediate care and then flow into the community with the community support and that support is getting so fragmented. We do our best but…

Identification code 83

2) In oral and written communication within and across teams with:

Various attempts (flow sheet, communication book, et cetera) had been made between November 2007 and February 2008 to update the care assistants on the care they were to provide during their shift. Simultaneously, only the qualified nurse(s) received a detailed report at shift change and the care assistants continued to be excluded from the weekly team meetings. Furthermore, they continued to chart in a separate location from the other members of the MDT.

Give them a place to communicate the same as us. Involve them in the MDT. Why are they not part of the teams? At the end of the day we all swan off and they are left to pick up the bits.

Identification code 103

Since the last set of interviews, in order to accommodate CSCI regulations, the charting on the unit had changed several times. The implementation of another new charting procedure did not go as effortlessly as management had anticipated, while the multiple sites for recording information continued to lead to difficulties in the exchange of information. Although information sharing had improved somewhat by making the nursing kardex open to all for recording pertinent information, a truly multidisciplinary patient record remained to be seen. The following quotes highlight the sense of inequality, inconvenience and potential discharge delays that the staff were attributing to the use of this nursing home style form of charting.

A real struggle is CSCI vs rehabilitation. The nursing home paperwork does not have a spot for the doctor's name. Nor does it have an area allocated for evaluation and the date to do so. It is based on a monthly schedule.

Identification code 111

The carers who are with the patients 24/7 do not write in the same place to the trained staff. CSCI affects communication. The notes are kept in two different places. The therapist notes and plan of care for rehabilitation are kept separate from the notes for the cares. There are two teams, the qualified and the care assistants.

Identification code 103

As depicted in #6 of Figure 4.2 the staff interviews exposed a difference in opinion amongst staff regarding what the vision for JON was and what an intermediate care unit was meant to be. Additionally, as seen throughout these themes, CSCI continued to be a focus of many concerns. The unit had recently passed a CSCI inspection with a 98% success rate. Pride in this accomplishment did not come through in the interviews. What was heard were comments such as:

We keep hearing XX say 'We are NOT a hospital, the service users can't expect what they got in hospital here'. Well I certainly didn't think we were going to be a nursing home when I signed up to come here…according to CSCI we are a pretty good one [nursing home]. Whatever happened to intermediate care?...The JON Foundation rules are governed by the CSCI people and the CSCI peoples' rules are too rigid for what we do here.

Identification code 71, 103, 111

3) Uncertainty

The staff struggled to understand what the true concept of a person-centred approach to intermediate care under CSCI regulations was meant to be. The feeling of a deficiency in the amount of support from the JON Foundation, as an organization, was evident in the following quote:

We are just floating really…I don't think we got really clear leadership and even [management] don't have it either. So it's not clear what we are suppose to do...We have lost some of the original ideals. We're left on our own now

Identification code 101, 111, 140

When questioned, the majority of the staff could not articulate what the vision for the unit was. What participants did articulate was that the unit focused on person-centred care and that person-centredness was seen to be a challenge.

We are left to sort it on our own. Someone [service users] complained because we made them go to the loo on their own. But we are a rehab centre that is what we are meant to do. Isn't it? They won't have anyone at home to help them. But no one has really told us what we are to do. So we just go about doing what we always have. But it is not our fault, but we are getting the cop for it.

Identification code 101

When questioned specifically about what model was being implemented, the majority of the participants responded with either 'none' or they did not know.

What model-ha? I thought we were using one more hospital based but the paper work just changed again so who can tell. I don't think models are really being followed.

Identification code 101

During the four-month interval between interviews, there was a higher than normal number of staff illnesses, resignations from the unit and unfilled maternity leave(s). As such, according to many of those interviewed, there were insufficient numbers of staff working on the unit during various shifts. Also, staffing numbers did not fluctuate in order to accommodate for the increased dependency of the service users.

You never know what you are in for; there is not a set number of staff on a day. One day it will be 4 staff on and one nurse and the next 5 staff on and 3 nurses.

Identification code 801

We are down staff. It doesn't really matter what colour the uniform. If there is a person there you know you are lucky. We are just struggling to get enough numbers to cover the shifts.

Identification code 112

According to at least one participant the unit was not 'short staffed'. Rather, the unit was suffering from a misconception of how the unit was to be staffed.

I am surprised. I am constantly hearing relatives saying 'you were short staffed the other evening.' When they come from hospital to here they are supposed to be given an explanation of what is provided here and what we are able to provide. You know *and there is a certain level of independence that is expected because they are in their own rooms with their own facilities and someone is not going to be coming in every 5 minutes. That is not how we should operate; we are not short staffed that is not the situation.*

Identification code 83

Whether this was a new form of staffing or not, the majority of the participants articulated being understaffed and '*run off our feet' (ID code 101*). As the previous quote illustrates, this short staffing or change to staffing schedules was also noted by the service users' families. The following excerpt illustrates how the increased dependency, insufficient staffing and change to staffing were having an effect on more than just staff numbers:

Some staff are activity directors but no activities have taken place for months. We are too busy just giving care. The dependency levels are too high and because we are a nursing home they don't increase the staffing numbers like they would in hospital. So who has time for activities? It's too bad really it's one of the reasons I came here. I thought it was going to be different.

Identification code 801

4) Care

There was apprehension over the difference in care being provided on the unit. Specifically, the irregularity of the care given to service users admitted into the beds purchased by three different groups. As previously mentioned, the unit consisted of respite care beds (3) and intermediate care (seventeen) beds which were purchased by two different PCTs. Staff were distressed over the uncertainty of how each group of SUs was to be treated. Unease over unequal rehabilitation for the SUs who occupied the beds that were under the control of two different PCT teams, is evident in the following quote:

The XX PCT wants it one way and the XX PCT wants it another. Than we have the respite people who we are meant to treat completely different. It is rather confusing.

Identification code 112

The physiotherapist and occupational therapist were originally charged with providing therapy to all thirteen of the seventeen IC beds. By the time of the second set of interviews this allocation of care had been amended to include all seventeen IC beds. However, the number of dedicated working hours on the unit (eighteen per week for each therapist) did not change. By March 2008, it was announced that the number of therapy-assistant dedicated working hours on the unit would be increasing from half a day to three full days a week.

In regard to the service users being admitted into these beds, stress over inappropriate admissions persisted as dependency levels and length of stays increased.

We get patients who shouldn't be here, they are medically unstable...several have died quite quickly within coming here, and others have been here for so long which is inappropriate to a rehab centre wouldn't you say?

Identification code 101

5) Education and training for staff

As of February 2008, the unit was no longer providing any rehabilitation/ intermediate care training. Furthermore, in-house education sessions with the team's physiotherapist had stopped altogether. Staff voiced a keen desire to increase their skills and knowledge surrounding intermediate care. However, health and safety training provided the only new educational opportunities presented in the four month period since the last set of interviews.

I've worked in nursing home and care homes and it's not much different. There are no courses on rehab that we can do here.

Identification code 910

During an innovation journey, the initial start up phase is dominated by a sense of euphoria and confidence in the innovation's success. The dynamics change as the innovation progresses into the developmental/implementation phase. At JON annoyance and frustration were evident when the initial excitement waned and the reality of the difficulties involved with implementing PCIC took hold of the journey (Van de Ven et al., 1999). At JON, the change in dynamics and the resulting discontent within the team was evident during the second set of interviews and continued to be ever present during the third and final set of interviews.

4.5.3. Third interview session

The analysis from the final set of interviews found no significant changes from those generated during the second set of interviews. Staff commented on an autocratic leadership style that was *'even stronger then before' (ID code 140*). There had been no new education sessions. Attendance at the MDT meetings was sporadic and staff morale was at an all time low. As such the third and final set of qualitative themes is the same as that identified in section 4.5.2.

Although no new themes were generated what did become apparent from the interviews was that staff were finding ways to navigate through this time of uncertainty. The following quotes emphasise where the staff were at the time that data collection ceased.

I think that generally we have a nice atmosphere and generally people can sort of sort out their issues together…um without involving anybody else.

Identification code 610

I think it is coming along; we have sussed each other out and know where each other is coming from now.

Identification code 112

I just think we need to go back and look at the model and the team work. Back before the unit opened…it is kind of a look how far we have come and there is just this little bit to sort out now. So it could be quite satisfying really couldn't it?

Identification code 140

At the end of the three sets of staff interviews there continued to be a sense of optimism amongst staff. This is illustrated in the following quote that focused specifically on communication:

I just feel it is a communication issue right across the board but not with individual members anymore, just in general. Because as individuals we are all listening to each other. If we could get our communication and probably respect for each other improved it would be even better for the patients. Which would be great.

Identification code 140

4.6. Normal group functioning

Over the year long data collection period staff repeatedly expressed the desire to deliver quality intermediate care and work effectively as a multidisciplinary team. There was a plethora of comments focusing on positive individual working relationships. However, equally represented were comments detailing a lack of cohesiveness as a team. Staff were perplexed as to why the team itself was fragmented when all individual members were keen to be effectively delivering this new form of care. They were confident that if the team was functioning 'normally' the delivery of PCIC on this unit would have been less challenging. According to Van de Ven et al. (1999) setbacks and mistakes are an expected component of every innovation journey. Furthermore, the literature on group functioning indicated that JON was experiencing behaviours that were indicative of a new group and standard for their stage in team development. Understanding 'normal' group functioning was crucial to exposing some of the key elements of JON's innovation journey. As such this section which is both a discussion and a finding is incorporated into this chapter.

Once an innovation process takes form there must be a way to support the efforts. Team building is an approach that can add strength to an organization in the innovation journey. Cummings and Worley (2001) define team building as 'the process of helping a work group become more effective in accomplishing its tasks and satisfying the needs of group members' (p. 676). After all it is not individuals who embark on the innovation journey but a number of teams working together. The following sections focus on describing the stages of group development. Accompanying this are examples of how the team at JON, although at first glance dysfunctional, was developing in a manner that was indicative of normal group functioning. JON's group functioning provides a comprehensible example of the flexible and fragile nature of relationships that exist amongst various participants in the innovation journey.[3]

Within an innovation journey the members of the journey engage in a variety of relationships. No one group or relationship is self sustaining nor do they possess all the resources, competencies and legitimacy necessary to develop and implement the innovation alone. As such, when an organization embarks on an innovation journey it does so by entering into a 'web of cooperation, competitive and regulatory relationships' with other members in the innovation journey (Van de Ven et al., 1999 p. 125). The three teams that merged to provide intermediate care at JON consisted of professionals and carers from the local PCT, from JON and Social Services. At first glance one might look at the members of these three groups, being health care and social service professionals, and anticipate obstacles to combining health and social services. In their attempt to provide person-centred intermediate care the JON Foundation was cognizant of the need to increase the interdependency of these groups of professionals. The active involvement of both sectors was deemed to be crucial in preventing the admission of frail older people to hospital or long term residential care, while at the same time, facilitating the discharge from hospital once medical treatment had been completed (personal communication, CEO, 2007).

Although the history of formal collaboration between social services and primary health care is not extensive it is the topic of a great deal of literature (DH, 1998; Hudson, 1999; Rummery & Glendinning, 2000; Glendinning et al., 2001). It is not the intention of this study to go into details of the historic divide, nor the recent examples of collaborative practice between these two sectors; this is not an oversight of the study but is a result of the findings. The social workers, physiotherapists, occupational therapists and some of the nurses and carers who were providing the intermediate care service at JON, had been functioning as a team in a previous

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[3] Some of the literature on team work/group development identifies a group and a team as two different entities however, in the following discussion the words 'group' and 'team' are used interchangeably.

community based hospital. According to staff interviews, due to their previous working conditions, this 'team' had developed a professional sense of understanding, trust and respect for one another. Qualitative data from the staff interviews indicated that despite their unpromising history this particular group of social services and health care practitioners and carers had a highly effective collaborative relationship. The following quotes are indicative of this relationship:

[We] functioned as a highly effective team.

Identification code 140

We sorted through who worked for who [meaning health and social care] years ago and just worked very well together. We had a system.

Identification code 103

It worked so well for 5 years as a team. We were all so glad to be staying together as such a strong team.

Identification code 610

We worked very well together... we didn't have the problems others have. Oh I suppose at the beginning we may have but for a long time we have been working together as one team. Not really focused on the social health split, that just isn't us.

Identification code 94

JON's innovative model of person-centred intermediate care was being introduced and implemented within the health and social care delivery of this unit and the need for effective interdisciplinary collaboration was critical. Although a collaborative relationship existed, at least in one of the previous teams, the new JON team was an amalgamation of three separate teams. Within this new JON team, relationships were in the early stages of formation. Membership of this MDT varied in regards to preparation, specialities and assignments. During this time of change, in order to have their daily practice run in an efficient manner, all team members were looking towards management to play a significant role in promoting collaborative practice amongst themselves and amongst the larger organizations (The JON Foundation, PCT, social services). The team was collectively looking for someone to take the lead in promoting an atmosphere of open communication, commitment to resident care, and mutuality of concerns. The team was not looking towards management to assume sole responsibility for the effectiveness of the team. Rather the MDT was looking towards management to be leaders. To integrate the daily operational activities of the nursing team on the unit with the other disciplines that made up the MDT, as they jointly planned, implemented and evaluated their own form of intermediate care. There were many opportunities to facilitate this cooperative collaboration through direct and indirect activities. However, the ability to achieve the best possible results in a congenial and collegial manner was not achieved as often as the team had expected. This was as a result of two powers that were in play: 1) during the team's first two years of functioning, due to structural changes, three of the original four intermediate care managers (PCT and social services) had been relocated and 2) an autocratic leadership style was dominating the MDT.

The loss of the original leadership team members and the autocratic leadership style dominating the unit had a negative effect on the team's ability to have control over its practice, shape the direction for its future and strengthen the overall collaboration of its members. By the time the first set of staff/informant interview took place poor communication had permeated the MDT and was beginning to erode the team's ability to function effectively. According to the qualitative findings the team was being asked on the one hand to share power with management and to assume increased accountability for their practice whilst at the same time, feeling disempowered to do so as a result of what they had identified as autocratic management. In regard to Van de Van et al.'s (1999) model this is what happens when the critic role goes unchecked by the counterbalance supplied by a mentor leader. In JON's case the mentor role was left vacant due to the PCT restructuring.

A successful team completes its tasks, maintains good social relations and promotes its members' professional and personal developments (Squires & Hastings, 2002; Leathard, 2003; Levi, 2010). The use of emotional labour (see section 6.3.) allowed JON's team to complete its task of providing intermediate care to the service users on the unit. Whilst at the same time, the organization of the JON Foundation (at the beginning of data collection) was also offering the team various professional training courses. It was the team's inability to maintain social relations and promote its members' personal development that seemed to affect the success of this team. The team members' articulated pride in their ability to provide intermediate care was inconsistent compared with their expressed concerns with the functioning of the team. According to psychologist Bruce Tuckman (1965), this sharp fluctuation in attitude about the team and the innovation's ability to succeed is a typical and inevitable aspect of team building.

Tuckman first introduced his model of group development in 1965 and maintained that the phases of ‘Forming’, ‘Storming’, ‘Norming’, ‘Performing’ and the later addition of ‘Adjourning and Transforming’ (Tuckman & Jensen, 1977) were all inevitable and necessary aspects of group development. This seminal work in group development has been used widely in management theory and frequently used to describe the behaviour of existing teams. Following the analysis of the staff interviews within this study, it was evident that this team’s group dynamics could be further illustrated and described effectively through the use of Tuckman’s model. As such the subsequent section of this chapter focuses on describing how JON’s MDT’s behaviour and actions corresponded with those described by Tuckman’s model of group development; specifically, the forming and storming phases of this model.

According to Tuckman (1965) the first phase of group development has been paraphrased as the ‘courteous’ stage, in which the team begins to form and seeks to identify the concept of the team and their individual roles within it (White, 2009). During this stage, for the most part, teams are positive as members desire both a sense of acceptance by the group and a desire to establish that the group is ‘safe’ (Tuckman, 1965). Informal leaders within the group begin to emerge as individuals’ personal relations are characterized by dependence and a need to feel protected. Thus, members seek out leaders for guidance and direction. Members begin to accrue impressions and information about the similarities and differences among them (Johnson et al., 2002). Serious topics and feelings are avoided as rules and behaviours are kept simple in an attempt to avoid controversy. At this stage no one has offended anyone yet. However, in order to emerge successfully from this stage and progress to the next, members must relinquish the comfort of non-threatening topics and risk the possibility of conflict (Tuckman, 1965).

At the time of data collection, JON’s MDT had been functioning for just under a year. During the initial interview sessions staff frequently made reference to the euphoria they felt when the team was originally developed. The team expressed a sense of excitement, anticipation, confidence and pride in being chosen for the task of implementing intermediate care in this facility. During the innovation journey Van de Ven et al. (1999) refer to a ‘grace’ period in which a ‘honeymoon’ period exists. This honeymoon occurs when the innovation is launched as a relatively simple development (p. 34). This period precedes the fireworks that accompany the innovation proliferating into numerous ideas and activities that diverge, converge and parallel one another. According to Tuckman’s theory, these feelings are indicative of thoughts commonly experienced during the forming stage of a team’s development.

The next stage of Tuckman's model is known as the storming phase. This stage is characterized by competition and conflict as team members confront each others' ideas and perspectives. The honeymoon is over: individual members begin to disagree and blame the team concept and overall vision for the unrest felt within the group. An increased desire for clarification of the team's overall structure and commitment is seen as members seek to identify levels of responsibility and how their practice will be evaluated. Behaviours reflect conflicts over leadership, structure, power, and authority as the team focuses on praxis. Personal relations are fraught with disagreement and blame, as individuals attempt to structure their feelings, ideas, attitudes and beliefs to suit the group organization. The discomfort generated during this stage can result in a dichotomy in team behaviour. This dichotomy is a result of some members remaining silent, whilst others attempt to dominate, as a means of dealing with the emerging hostilities and issues of competition (Tuckman, 1965; Tuckman & Jensen, 1977; White, 2009). This stage can be unpleasant and contentious. It can also be resolved quickly when supervisors are accessible, willing to listen to members and able to provide clear guidance on professional behaviour and decision-making. At this stage, without the necessary support, teams may fail to progress to the 'norming' phases, as they are unable to display the necessary acceptance and patience needed to navigate successfully through this stage of the model (Tuckman, 1965).

During the data collection phase, even though there was consensus on some of the underlying issues (e.g. patient care), team members were refusing to accept various tasks and were arguing amongst themselves. The following thoughts and activities were conveyed by the study's staff participants.

I'm not going to take on the role of charge; I don't care what she says.

Identification code 111

Staff were exhibiting a sense of defensiveness. They were taking sides and questioning the vision of the team and the vision of the organization and managers who brought the team together.

I came here to give rehab to people not to work in a care home.

Identification code 801

It's no different than what I did in the nursing home. That's because of CSCI I wouldn't have brought them into this.

Identification code 501

Disunity and increased tension were palpable on the unit. According to Tuckman (1965) these traits are consistent with a group who has not yet been able to successfully navigate through the storming phase.

Groups must first progress through each phase in order for latter phases to be successful. However, teams can fluctuate between phases during certain circumstances as they react to new challenges (Johnson et al., 2002). There was a hint of this during the second set of interviews when staff began to express some optimism. This hopefulness is illustrated in the following comments:

I am happy to say things have improved a bit.

Identification code 140

Things are getting better, slowly.

Identification code 610

This optimism appeared short lived. Between the time these data were collected and the time the next set of interviews were held (which produced more data indicative of ineffective functioning), there was a change in management for one part of the MDT. This alteration in the team's membership had a compounding negative effect on its functioning. A primary source of instability within a group is membership turnover. A change in a team's membership from either an addition of a new member or as a result of the loss of a current group member can lead to instability within the group (Arrow et al., 2002). In this case the management changed. As such, not only was a current member lost but a new member entered the team. This resulted in instability. This change in membership may provide an answer as to why the team was unable to move out of the storming phase.

According to Van de Ven et al. (1999) setbacks and mistakes are frequently encountered as plans get derailed and unexpected environmental events alter what was anticipated for the innovation (Van de Ven et al., 1999). Participant participation in the journey can itself cause setbacks due to the fluid nature of individuals' involvement with the innovation. This is because members tend to be involved on a part time basis and have high turnover rates. For this particular innovation within the first year of functioning, the PCT and social services managers, who were involved in the initial development of the unit, had relocated to other positions. The remaining member of the original four (in charge of developing the intermediate care practice on the unit) was a JON Foundation employee.

Another possible explanation for the team's inability to navigate out of this stage pertains to the autocratic leadership that was alluded to earlier in this section. Staff interviews were saturated with criticism for what the team believed to be an autocratic leader. Tuckman (1965) acknowledges the need for such a leadership style. Clearly describing how, during the first two phases of group development, supervisors need to be directive in regard to decision making and acceptable professional behaviour for the group. However, of importance is that managers and teams need to find a balance between authority and responsibility. Achieving balance between the two can be challenging as the team matures and is able to handle more authority and responsibility, and needs less supervisory input (Levi 2010).

At the time data collection ceased, the JON's MDT remained in the Storming phase of this model. Had the team been able to navigate through this stage they would have entered into the Forming phase which is indicative of a team which has established cohesiveness and commitment to its tasks. The norming phase is underpinned by the members' ability to seek out and establish alternative ways of working together and display appropriate behaviours. When the data collection ended, this behaviour was not evident on the unit.

Once a group has navigated through the norming phase a competent, motivated, interdependent, knowledgeable group enters the Performing phase. In this stage the group becomes proficient in decision-making without the need of supervision (Tuckman, 1965; White, 2009). Finally, the Adjournment phase occurs when the team has completed the task they were assembled for, and is ready to be dissolved. It has been referred to as the mourning stage, as there is a sense of accomplishment coupled with a reluctance to disband (Tuckman & Jensen, 1977; Johnson et al., 2002).

The team at JON, although essentially a new team, and in the early stages of group development, consisted of members from a previous team who had undergone the stages of group development and had emerged as a self-described 'highly effective team'. Narratives from individuals who made up this old team indicated that they were in the Performing stage of Tuckman's model. However, as a new group, the team was not at the Performing phase. The new team at JON was wedged in the Storming phase, yet some of the members were holding onto previous ways of functioning.

4.7. Summary of the chapter

At the time data collection ceased the unit had been open to NHS intermediate care patients for just over 21 months. The amalgamating of the MDT's skills, experiences and expertise and the forming of a unique set of policies and protocols that differed, at least in some part, from those which all had used previously, continued to be fraught with setbacks and problems.

The staff travelled through the developmental/implementation period of their innovation journey as they pushed and pulled through old and new to craft their unique model of person-centred intermediate care. Ineffective collaboration with teams outside the unit, and misunderstanding of the level of care available at the unit, meant that issues with transfers continued to arise. That being said the team was beginning to show renewed signs of optimism.

This concludes the staff interviews and the chronological account of JON's innovation journey. Chapter 5 will present the quantitative data and service users' feedback which will assist in measuring the progress of this innovation based on the founding organization's key indicators for success (see section 3.7.2.).

CHAPTER 5

THE SERVICE USERS

5.1. Introduction to the chapter

The information presented in this chapter was derived from interviews undertaken with service users admitted to JON's unit for intermediate care, and nominal and ordinal data gathered through routinely collected activity data. In keeping with the aims of this detailed case study and to assist with the appreciation of the analysed data the results are presented in the form of summaries, figures and diagrammatic flow charts, and the service users' perspective on the effectiveness of the PCIC model is also illustrated by individual quotes.

The study's service user sample came from a consecutive sample of service users admitted for in-patient comprehensive rehabilitation to JON's intermediate care unit during the study's data collection period (01.07.2007–30.06.2008 inclusive). Throughout this 52 week recruitment period, 168 service users were admitted to JON intermediate care unit, of whom 94 took part in this case study. The first part of the chapter focuses on detailing the demographic and clinical characteristics of this service user sample. The latter part of the chapter focuses on the service users' perception of the effectiveness of the care being provided on the unit.

5.2. Characteristics of the service user study sample

5.2.1. Demographic features of the service users

The 94 service users taking part in the study consisted of 93 Caucasians and 1 Asian who resided within the NHS's defined catchment area for this facility. There was a higher proportion of females, 68 (72.3%) to males 26 (27.7%), and the mean age of the sample was 84.0 years with a range of 40 years from 60 to age 100.

5.2.2. Clinical features of the study sample

The following section describes the clinical characteristics that the service users presented with at the time of admission to JON.

5.2.2.1. Referral category

The referral category recorded in this study refers to the location the service user came from prior to entering the intermediate care facility. Specifically, a service user could be admitted into this intermediate care facility directly from home as a ‘step up’ admission or directly from an acute care hospital as a ‘step down’ admission. Referrals into the facility were accepted from general practitioners, consultants, local rapid response teams and in-hospital referral nurses. Out of the participants (n=94), 19 (20.2%) were considered step up admissions, meaning they were admitted from home (n=7) (be it their independently owned home or their home in a residential care facility) or from a local Emergency and Accident Department (n=12). The remaining 75 (79.8%) participants were ‘step down’ admissions, meaning they were referred and transferred to the unit as inpatients from either local hospital #1 n= 59 (62.8%), local hospital # 2 n=13 (13.8%) or other n= 3 (3.2%) acute health care facilities.

5.2.2.2. Admitting diagnosis

This category refers to the primary admitting diagnosis that was determined by the referring practitioner and given as the reason for the service user’s referral to intermediate care. Out of the 94 participants the primary medical diagnosis indicated that 56 service users were admitted under the *Fall* category. This category was further divided into two sub-categories: *fall with fracture* 21 (22.3%); and *fall without fracture* 32 (34.0%). The remaining participants n= 38, were admitted under the following categories:

- *Functional impairment* 23 (24.5%). In general functional impairment is defined as difficulty in carrying out the tasks essential for independent living and self-care. This includes maintaining essential roles and desired activities that are seen as important to quality of life (Fried et al., 2004). This diagnosis encompassed a plethora of presenting conditions such as: urinary tract infection, inability to cope, unsteady on feet, unsteady gait, et cetera.

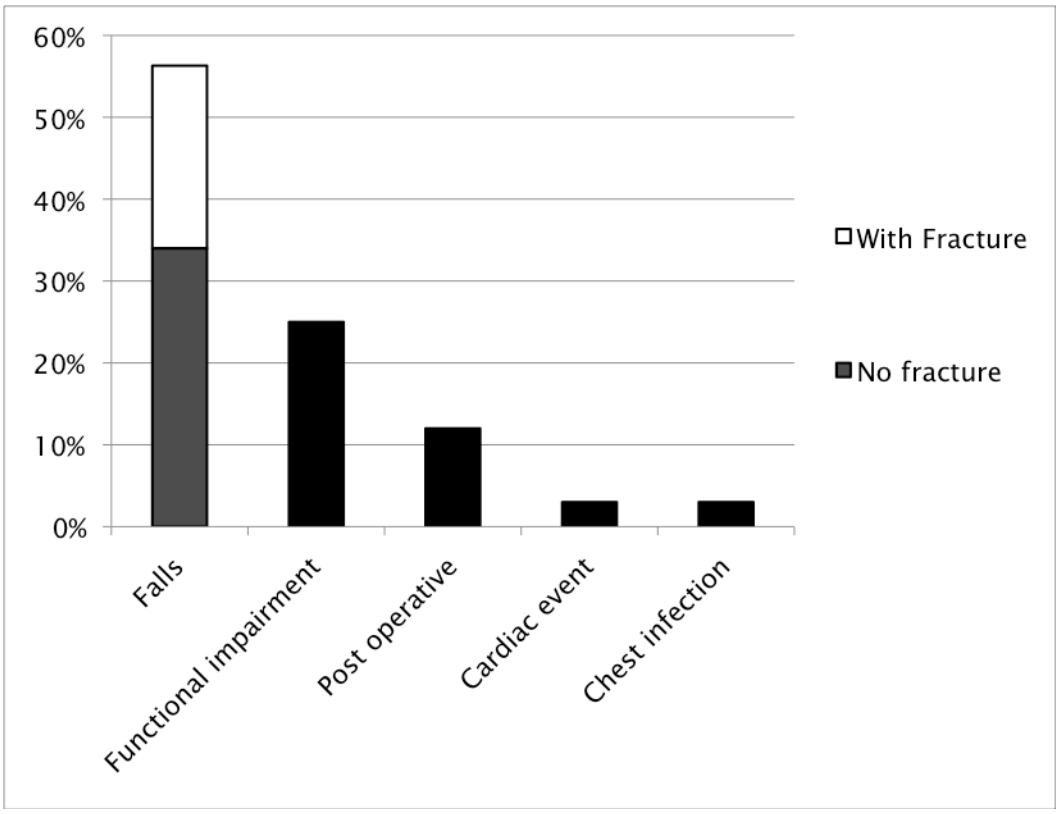
- *Post-operative care* 11 (11.7%). This category covered the service users who were 'medically' stable following their recent in-hospital surgery yet not functioning effectively enough in the area of activities of daily living to safely return home.

- Ca*rdiac event* 3 (3.2%). This diagnosis included those service users who had suffered a recent cardiac incident such as a stroke, myocardial infarction and/or a hypertension crisis.

- *Chest infection* 3 (3.2%). This category included those recovering from a diagnosed episode of pneumonia, bronchitis and/or asthma exacerbation.

- *Sort out medications* 1 (1%). This diagnosis was reserved for those service users who required medical supervision whilst having their medications altered in order to best meet their current health care needs (see Figure 5.1).

Figure 5.1 Frequency of admitting diagnosis n=94



No missing data on any parameter
Percentage depicts number of service users

5.2.2.3. Pre-existing medical conditions

This category refers to the secondary diagnosis which service users were admitted to the unit with (not as a result of). Of the 94 participants the majority, 60 (63.8%), had three or more pre-existing medical conditions at the time of admission, seventeen (18.1%) had two pre-existing medical conditions and 10 (10.6%) had only one pre-existing medical condition. There were 7 (7.4%) service users who had no medically diagnosed pre-existing ailment.

5.2.2.4. Level of social care

In England, when a patient receives care in their home from an external agency it is usually referred to as a care package. Care packages can be privately funded or fully or partly funded by social services. They consist of varying degrees of care (personal care to domestic services, e.g. grocery shopping) which can be provided over an extended period of time to meet any physical or mental health needs that have arisen as a result of disability, an accident or an illness. Information concerning the service users' level of social care (care packages) was collected as a means of assessing if there was a relationship between the level of care they were receiving at the time of admission and the level of care they required at the time of discharge. The review of care needs focused specifically on external agencies and did not include the contributions of family and friends as care sources. Of the 94 participants, 55 (58.5%) had, prior to this specific health care episode, been receiving some form of care package. The remaining 38 (40.4%) participants had no care packages in place at the time of admission. One (1%) participant was excluded from this category as the information was missing in their chart (see Table 5.3). Section 5.3.3. focuses on discharge level of social care and ascertains if there is a relationship between the pre- and post- level of care.

Table 5.1 Level of social care upon admission

Type of care package	n=93
None	38 (40.4)
Once a day	9 (9.8)
Twice a day	9 (9.6)
Three times a day	3 (3.2)
Other*	19(20.2)
Family support	15 (16.0)

Figures are numbers (percentages) of service users unless stated otherwise
***Includes support from friends and private shoppers**

5.2.2.5. Length of stay

One of the main admission requirements for JON was that each service user be assessed in order to ensure their need for care did not exceed 42 days/6 weeks. This timeframe was in keeping with the DH's policy guidelines for intermediate care length of stay (LOS) which advocates a minimum LOS of one week and a maximum LOS of six weeks (DH, 2001) (see section 2.3.2. for further details). The Estimated Length of Stay

(ELOS) was to have been agreed upon by the transferring nurse, the referring doctor and the service user. It was further documented on what JON referred to as the 'Transfer Document' and agreed to in writing by the transferring nurse and the service user. By doing so the service user entered into a contractual agreement with JON, whereby, they agreed to be transferred to JON and remain there as an inpatient for the approximated length of time that their treatment took (personal communication, CEO, 2007). The completed transfer document was to accompany each service user to the unit and become a permanent part of their in-house service user record.

The analysis of the ELOS data indicates that 12 (12.8%) participants did not have an ELOS recorded at the time of admission. Of those who did have data recorded, 8 (8.5%) had an ELOS of 1-7 days (one week), 35 (37.2%) had an ELOS of 8-14 days (two weeks), 24 (25.5%) had an ELOS of 15-21 (3 weeks), 9 (9.6%) had an ELOS of 22-28 days (four weeks), 3 (3.2%) had a ELOS of 29-35 days (five weeks) and 3 (3.2%) had an ELOS of 36-42 days (six weeks) (see Figure 5.3. for a comparison of the service users ELOS and actual length of stay (ALOS)).

5.2.2.6. Barthel index 100 admission score

This section of the analysis documents the service user's functional ability at the time of admission using the 100 point Barthel index (BI 100). Upon admission all service users (n=94) had a Barthel index 100 completed. The minimum admitted score was 3; maximum score was 88 and a mean score of 52.7, Standard Deviation of 19.1 (see Appendix 12 for a breakdown of scoring categories). Section 5.3.5. compares functional ability prior to admission (pre-score) and at the time of discharge (post-score) from JON's intermediate care service.

5.3. Outcomes for the study sample

This section presents the quantitative data collected for the following outcomes:

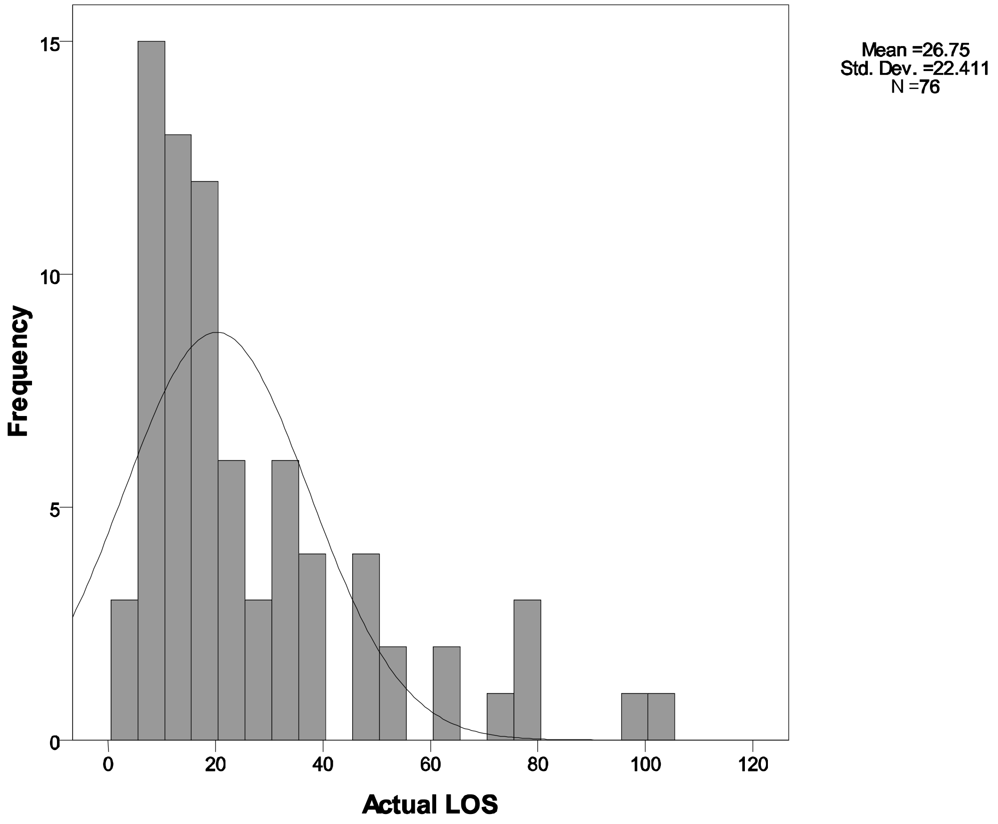
1. Actual length of stay
2. Destination at discharge
3. Discharge care package
4. Six week follow up location

5. Barthel index 100- change in score

5.3.1. Actual length of stay

The ALOS category was calculated using n=75 as eighteen participants had not come to an end of their episode of care at the time the study's data collection period was complete (n= 9 were still receiving IC on the unit, n=9 were transferred back into hospital) and 1 service user died on the unit. The analysis of the data for these 75 participants indicated that the ALOS ranged from 3 to 105 days.

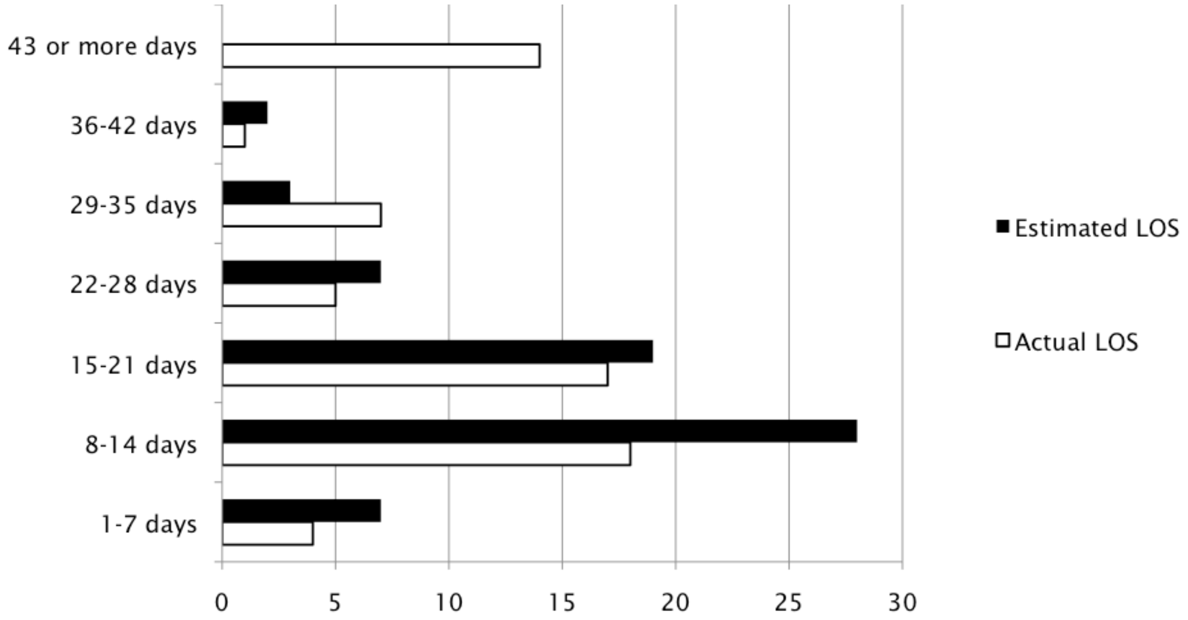
Figure 5.2 Actual length of stay (in days)



d

*** Frequency depicts number of service users**

Figure 5.3 Estimated length of stay compared to actual length of stay (n=66)



x represents number of service users

The statistics comparing these two variables indicate that data was missing for 28 (29.8%). Of the participants who did have a completed data set (n=66), 47 (71.2%) of them stayed longer than their ELOS, with 19 (28.8%) of those staying 43 days or longer, thus exceeding the Department of Health's guidance of between two and six weeks (DH, 2001).

5.3.2. Destination at discharge and at six week follow up

For the discharge destination n=85, as 9 service users remained on the unit when data collection ceased. As their episode of care at JON was not complete, they were excluded from all care outcome variables. Table 5.2 summarizes the quantitative evidence collected from the service users at the time of discharge and at six weeks post discharge.

When assessing the participants' six week follow up locations n=75, as 19 service users were excluded from this category. Of these service users, 10 had not been discharged from the unit (i.e. 9 still receiving care and 1 deceased) and 9 had not come to an end of their episode of care (having returned to hospital). Furthermore, during the study's developmental phase, it was indicated by the Unit Manger that the unit was concerned about service user follow up. For that reason, the Unit Manager contacted all service users six weeks post discharge and recorded their whereabouts. After six weeks of data collection the Unit Manager changed this protocol. For the remainder of the study, the post discharge follow-up information was no longer collected by the Unit Manager. At the six week follow-up time, for those service users who were still receiving a care package from this particular social services division, their whereabouts were able to be recorded. As a result of this change in protocol, 19 service users were unaccounted for as they were no longer receiving any form of care by these two particular social workers. These missing data and the implications, with regards to the functioning of the unit, and its implications for data collection are discussed in detail in chapter 6.

Table 5.2 Destination at time of discharge and at six week follow up

Destination at discharge from JON:	n=85
Home *	63(74.1)
Residential care	5(5.3)
Change to residential status	7(7.4)
Hospital	9(9.6)
Deceased	1(1.0)
Missing	9(9.6)
Destination of new residence:	n=7
Family’s home	2(28.6)
Respite care	1(14.3)
Warden controlled flat	1(14.3)
Residential care	3(42.9)
Destination at 6 week follow up:	n=75
Home	43(57.3)
Hospital	5(6.6)
Family member’s home	1(1.3)
Institutional care (see above for title)	4 (5.3)
Warden controlled flat	0
Respite care	1 (1.3)
Deceased	2 (2.6)
Unaccounted for	19 (25.3)

*Home signifies any discharge destination that is not a hospital, residential care facility (including warden controlled flat) or a family member’s home.

5.3.3. Discharge care package

Table 5.3 summarizes the evidence collected regarding discharge care packages for which data were available. For this category n=75 as 19 service users were disqualified from this category because their care was ongoing (n=9 re-admitted to hospital, n=9 still on the unit) and 1 service user died on the unit. For this category 7 service users had a change in residential status, i.e. living at home prior to admission and transferred to residential care at discharge. Although one could argue that these 7 service users fall under the ‘required more care’ category, for this study, they were classified as ‘change in residential’ status.

Table 5.3 Discharge care package

Discharge care package	n=75
Higher level of support than at the time of admission	42 (56.0)
Lower level of support than at the time of admission	0
Same level of support as at the time of admission	25 (33.3)
Change to residential status	7(9.3)
Missing	1(1.3)

5.3.4. Barthel index 100

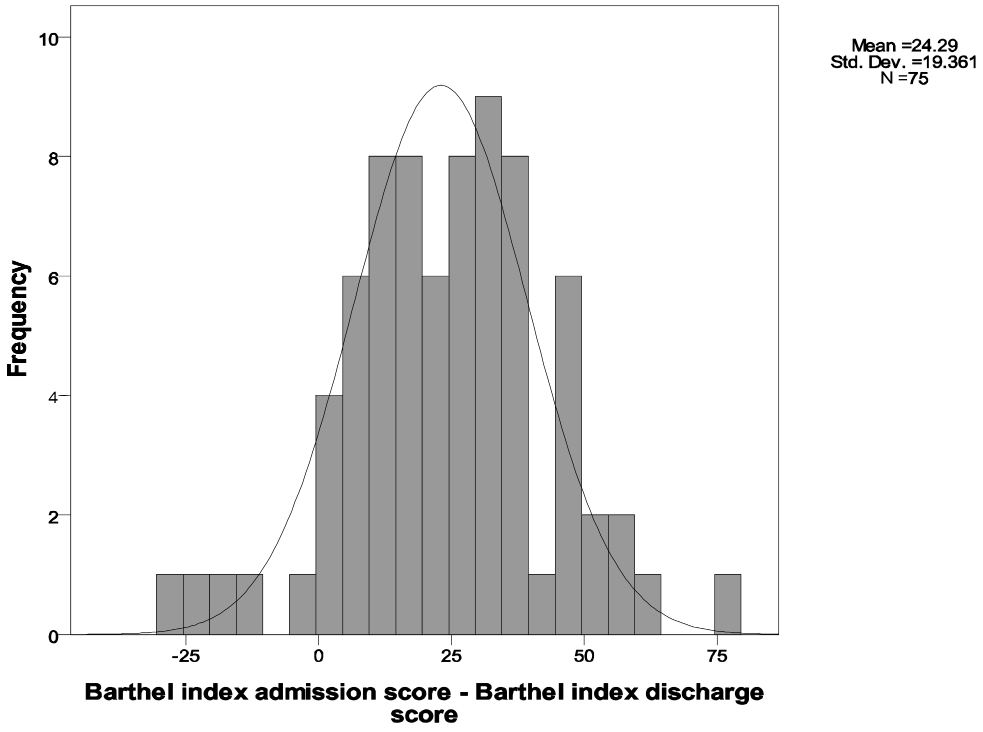
Analysis was undertaken in order to test the relationship between the admission and discharge Barthel index 100 scores. As with many of the other care outcomes, 19 service users were excluded from this category as 9 remained on the unit, 9 were re-admitted to hospital and 1 died whilst in care. Therefore, a change in Barthel index 100 score was calculated for all service users (n=75) who had a completed Barthel index 100 set (Barthel index 100 at admission and Barthel index 100 at discharge). The change in Barthel index 100 scores for this reduced sample (n=75) indicated 5 (6.6%) service users had a drop in their Barthel index 100 score during their stay at JON (i.e. their pre-score > their post-score). This drop in scores ranged from 1 to 28 points. For 4 (5.3%) service users there was no change in their Barthel index 100 score (i.e. pre-score = post-score) and 66 (88%) service users had an increase in score (i.e. post-score > pre-score). The increase in scores ranged from 5 to 76 points. Table 4.4 provides a summary of the central tendencies for the Barthel index 100 at the time of admission (pre-score) and at the time of discharge (post-score) and Figure 4.4 illustrates the change in score values.

A paired-sample t test was run in order to compare the means of the pre-score and post-score. Table 4.3 documents the mean score of both variables as well as that for the change in Barthel index 100 score. The paired t-test indicated a significant outcome ($p<0.001$) and allows one to conclude (with 99.9% confidence) that the 24.3 point mean change towards increased functional ability is statistically significant. This finding will be further discussed in chapter 6.

Table 5.4 Barthel index 100 scores

Barthel index 100 score at admission :	n=94
Minimum score	3
Maximum score	88
Mean (SD)	53.95 (19.1)
Barthel index 100 score at discharge:	n=75
Minimum score	28
Maximum score	100
Mean (SD)	78.2 (14.2)
Change in Barthel score:	N=75 Difference in means (95% CI)
Minimum	-28
Maximum	76
Mean (SD)	24.3 (19.6)
Correlation	.350
Sig. (2-tailed)	.000

Figure 5.4 Change in Barthel index 100 scores



*Frequency denotes number of service users

** 100 point scale with higher values indicating better function

In keeping with the aims of the study, the wishes of the study's funder (the JON foundation) and the fact that there was no control group and too many influencing factors that were outside of the study's control, no further statistical tests are included in the presentation of these findings.

5.4. Satisfaction questionnaire

Understanding the extent to which service users were satisfied with the care they received whilst at JON was an important part of this study. To that end the use of a satisfaction questionnaire, developed specifically to include the key elements of satisfaction with intermediate care, was given to SUs during their discharge interview (see Appendix 10). Furthermore, the tendency to agree (acquiescence) and the tendency to give the socially desirable response (social desirability) when completing a satisfaction questionnaire was considered and addressed by providing areas for free text as well as discharge semi-structured interviews. The goal was to expose any potential floor or ceiling effect of this questionnaire with supporting or contradictory remarks. As such, in this section comments from the free text are presented alongside the quantitative data in order to assess the responses from the satisfaction questionnaires in the context of the service users' narratives.

This questionnaire was administered to 59 participants. The following are the reasons why the remaining 35 service users did not receive a questionnaire. As stated with other care outcomes variables, 1 participant died and 9 participants had been admitted into hospital. For those in hospital, although their stay at JON had come to an end, their episode of care had not. Due to their compromised state it was deemed unethical to ask them to complete a satisfaction questionnaire. A further 9 participants remained on the unit at the time the data collection ceased. Thus, they were excluded from receiving the questionnaire, as their care was ongoing. Out of the remaining service users (n=75), 16 participants were considered missing as they were discharged before I was notified. This resulted in the service users being discharged prior to receiving a questionnaire or discharge interview (see chapter 6 for further details).

The following is a summary of the results of the questionnaires completed (n=59). The findings are clustered according to the specific topics that addressed the concerns of intermediate care. Specifically, the clusters are: overall quality of care, humaneness (warmth, respect, kindness, willingness to listen, interpersonal skills), competence, outcomes, facilities (equipment), access (convenience, hours, availability), informativeness (regarding treatment, procedures or diagnosis) and attention to psychological problems (see Appendix 13 for a breakdown of response rates and Appendix 14 for more free text comments).

The majority of the participants (91.6% 'agree/strongly agree') were pleased with the amount of recovery they made during their stay on the unit and (96.6% 'agree/strongly agree') reported the staff did their best to assist them in becoming more independent whilst doing all they could (96.5% 'agree/strongly agree') to make them well again.

It should get all the stars it can.

Identification code 211

[The] professional help was superb.

Identification code 284

Very pleased with what you have done for me. Thank you very much.

Identification code 229

On the topic of 'informativeness' (Wilson et al., 2006) 79.7% of respondents agreed/strongly agreed that the staff kept them apprised of the care they were receiving. A further 8.9% of SUs responded 'don't know'. With regards to staff providing them with all the information they requested about their current condition, 69.5% of service users agreed/strongly agreed and 13.6% responded 'don't know'.

While 74.6% of SU respondents reported being able to talk to the staff about any problems they may have had, 8.5% said they did not know. Of the service users, 66.1% agreed/strongly agreed that the staff always had time for them whereas 5.1% did not know. Concern over staff's availability was demonstrated in the following comment:

The lady, who brought me in initially, left me in my room with no access to any of my things.... if you press the buzzer; it is a lottery as to when or even whether it is answered. So if you need help to the lavatory you need to anticipate by about ½ hour. [This] isn't really acceptable.

Identification code 236

The questions that focused on staff competence establish that 89.9% agreed/strongly agreed that the start of their care was efficiently managed and that for 84.8% of the respondents staff were careful to check all details prior to beginning their care with 5.1% responding 'don't know'. Whereas 13.6% of service users said they did not know if staff communicated effectively with one another, 76.3% agreed/strongly agreed that they did. There was concern voiced in the free text around information being successfully relayed from one group of staff to the next during shift change. As seen in chapter 4 (section 4.6.2.1.(2)) staff voiced similar concerns:

I don't think on change-over they get all the information they need. Some of them don't know what I told the staff on before them. It is not passed on or it doesn't seem to be.

Identification code 241

I am writing this on behalf of my mother who is unable to write. My mother thought the facilities/care was very good- I myself felt there was a lack of communication with *the various shifts about the things I had asked for my mom and the info was not passed on.*

Identification code 252

The questions focusing on humaneness and overall quality of the service indicated that 96.7% of all respondents believed they were treated with kindness dignity and respect and 86.4% agreed/strongly agreed that the facility had all the equipment needed to care for them. Within the free text, the following comment spoke to the care received on the unit:

You are well looked after. It is so lovely ...I got all the attention I required...it is a beautiful place...I have nothing but praise for the care that I needed...They were all wonderful. I don't have anything negative to say at all.

Identification code 213, 233, 277 & 238

Finally, focusing on recovery, 91.6% agreed/strongly agreed that they were happy with the amount of recovery they made whilst being cared for on the unit, with 3.4% of SUs responding 'don't know'. When asked if they were well prepared for when the service finished providing care for them, 23.7% responded 'don't know' and 67.8 % agreed/strongly agreed that they were prepared. However, when questioned if the service finished providing care too early for them, 33.9% responded they did not know and a further 43.9% disagreed. The following quote from the free text speaks to the higher number of service users responding 'don't know' to this category:

I don't know [referring to being ready for home]... I am prepared to give it a try. I won't know if I am prepared until I get home really. Won't know if it is effective until I get home.

Identification code 260

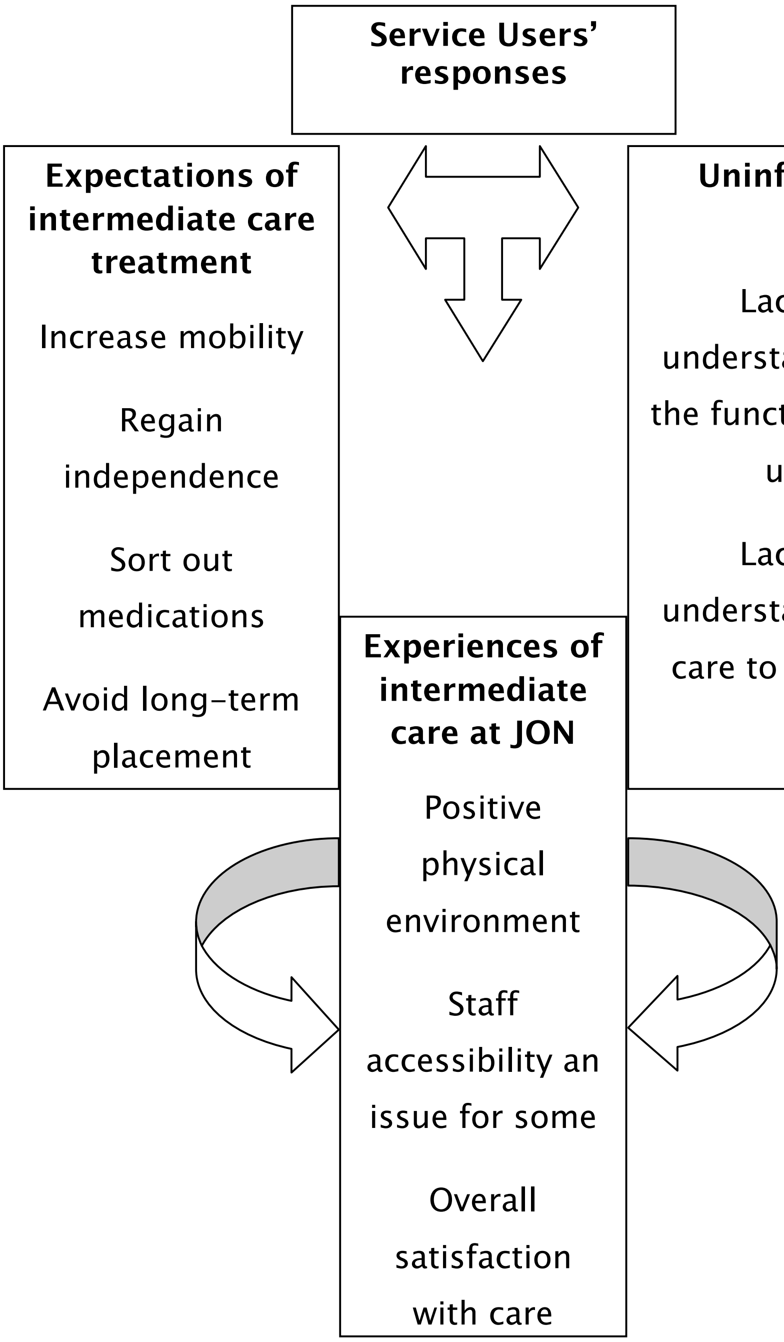
5.5. Service users' perspectives

During the study's developmental phase the JON Foundation's CEO was questioned on how the JON Foundation management would know if the unit was functioning to standard. The CEO replied, 'If we are doing what the service users want us to do and they improve during their stay then that is value for money to us' (personal communication, CEO, 2006). Bearing that in mind, the semi structured interviews with service users focused on identifying at the time of admission what the service users expected from the intermediate care service that would be provided for them on the unit. At the time of discharge, the interviews sought to establish if the service users' expectations of the service were met and the reasons why or why not (see Appendix 9 for interview guide).

5.5.1. Service Users' perceptions

The service users' qualitative data exposed the following themes as illustrated in figure 5.5 and discussed in detail in the text that follows.

Figure 5.5 Themes that emerged from the Service Users' Qualitative data



The Following thematic analysis of the first set of interviews (n=94), two themes emerged. They were:

1. Intermediate care treatment – During the admission interviews, the majority of SUs expected to receive intermediate care whilst being admitted to JON. The service, according to the narratives, would offer rehabilitation to assist in increasing functional ability, as well as organizing appropriate care for home.

2. Uninformed – a sizeable minority of the service users had no idea what to expect from this service. Some participants were completely unaware that this unit was an intermediate care facility.

5.5.1.1. Intermediate care treatment

For the SUs who understood that JON was an intermediate care facility, the majority of their expectations focused on the service providing an opportunity for them to a) increase mobility, b) regain independence, c) sort out home care and d) avoid long term placement.

Many service users voiced concern over a recent loss of mobility. These changes in mobility were secondary to a variety of factors (e.g. recent fall, surgery, unknown). Regardless of the underlying aetiology, the majority of the service users voiced a keen desire to get back to their previous level of mobility or at minimum regain sufficient mobility to return home.

I need to improve my independence so I am like I was before my surgery...To get me on my feet again, mobile, succinct and able to carry on a normal life as much as possible...To make sure I am properly mobile to get home.

Identification code 213, 228, & 243

A focus on regaining lost independence was also clearly evident in the interviews with narratives similar to the following quote:

I used to love walking. I do, did all my own house work with my husband and shopping with my daughter and I would like to get that back. I don't like having to rely on others.

Identification code 252

The need for assistance in sorting out care packages was also expressed.

I was hoping they would sort out me and my wife's problems about getting care allowance... Social workers to get things organized for me to go back home... We are struggling at home. Some care for my wife. We used to pay a cleaner but now can't afford it...My husband's 87 and he needs help with me.

Identification code 248, 279,284, 219

The desire to go home and avoid being placed in a care facility was articulated by several service users

Get me back to my home rather than a health unit.... To help me get stronger and go back to my home.

Identification code 232 & 248

There were narratives that spoke to the loss of dignity that can result from a loss of independence. The desire to improve mobility in order to regain independence and lead a dignified existence is evident in these quotes:

Help get my strength back as I can't get out of bed at night. I hate to wet the bed but I don't have the power to get out of bed sometimes. So give me help with that... I was at home with my son; he can't cope with me weak. I need to get back home strong.

Identification code 278 & 281

5.5.1.2. Uninformed

The following quotes focus on some of the service users' lack of understanding of the unit as a whole, and or the care they were to receive whilst being cared for on this unit.

I wasn't looking for anything. I didn't even know the service existed and I didn't know what to expect but was pleasantly surprised to be treated like Royalty. Never could you say anything negative about the NHS again.

Identification code 248

We did not know it was a rehab centre. We were not told that at the hospital.

Identification code 297

I really did not know what to expect.

Identification code 275

We know nothing about this place.

Identification code 248

No information at all from the staff apart from the ones here about the care I would get when I was here. When I am transferred [to the unit from the hospital], we knew nothing about the place.

Identification code 261

5.5.2. The service user's experiences

Upon discharge service users (n=59) were asked if the intermediate care service they received at JON met their expectations. The thematic analysis of this data indicated that there were three areas the responses focused on. They are:

1. Positive physical environment- the physical environment was conducive to care.

2. Staff accessibility issues- a minority of service users were displeased with staff accessibility.

3. Satisfaction with care- the majority of the participants were pleased with the care they received. Even some of the participants, who felt they did not improve to the level they had originally planned for, were pleased with the service.

5.5.2.1. Positive physical environment

All comments focusing on the physical environment at JON were positive.

The food, the clean towels it was all very special and a special relationship with the night team.

Identification code 248

It is a beautiful place.

Identification code 234

It's like a hotel here it is gorgeous.

Identification code 235

Everything else is beautiful- the building, the rooms, the food.

Identification code 218

5.5.2.2. Accessibility issues

A minority of service users expressed concern over staff availability and communication problems. These concerns are highlighted in the following comments:

I don't think on change-over they get all the information they need. Some of them don't know what I told the staff on before them. It is not passed on or it doesn't seem to be.

Identification code 241.

I am writing this on behalf of my mother who is unable to write. My mother thought the facilities/care was very good. I myself felt there was a lack of communication with the various shifts about the things I had asked for my mom and the info was not passed on.

Identification code 252

This narrative highlights the displeasure one SU experienced, whilst concurrently drawing attention to the dichotomy that was occurring on the unit (see chapter 6 for detailed discussion of this mis-match).

They are too busy here; it took me nearly a week to get physio over Easter. I came and they didn't want me here they were too busy and short staffed. I'm better to go home and have my carer help me. They are always in a terrible rush as someone has called in sick. They are jolly nice people so I don't blame them.

Identification code 273

5.5.2.3. Satisfaction with care

The majority of service users were pleased with the care they received on the unit. The following quotes illustrate this.

I can't walk very well. I hope I've gotten stronger. It is very good, very helpful.... They tried to get my legs proper again but there is not a great deal of improvement, but I am very pleased with all they did for me.

Identification code 268

Yes by all means [the service provided what I wanted it to]. Everything helped me. They are so lovely here; it is a beautiful place.

Identification code 234

I agree with every word I own. I think the confusion was due to the hospital rather than JON. I complained to the person in charge and they rectified it.

Identification code 261.

They've helped me with my independence. I was fairly independent before I was hospitalized and they got me pretty close to that again.

Identification code 214

You have done wonders for me it has been wonderful. They are all such a lovely bunch, they really are. They did it all to help me in the beginning now I'm doing it for myself.

Identification code 238

I am glad to be going home. Have done everything I needed.

Identification code 254

They are very noticing here. I expect their willingness to help and their understanding was the best part of the service here.

Identification code 221

This completes the presentation of the service users' data. These findings and those presented in chapter 4 are triangulated in chapter 6. The mis-match that was exposed through this process is discussed in detail.

5.6. Summary of the chapter

In summarizing the service users' evidence, it can be concluded that 94 participants entered into the study. This number did not meet the study's anticipated 118 sample size. In addition this reduced sample size was further decreased in many of the care outcome categories by 19. This was a result of 1 service user having died on the unit and a further 18 having not come to the end of their care at the time data collection ceased, with 9 of these 18 being admitted to hospital and the rest (n=9) remaining on the unit. This number (n=75) was further decreased for various categories, due to a) data not being recorded by the staff at JON and b) staff not notifying me of impending discharges and therefore, categorized as missing. Therefore, when assessing these data it must be noted that the majority of the percentages presented in this chapter are representative of a portion of the overall sample size.

From the demographic data collected on the whole sample (n=94), the research found the participants in the study were predominantly English speaking Caucasians (n=93). The review of ages concluded that the majority of the participants accessing the service at this facility were over the age of 80 (mean age 84.0). The UK Office of National Statistics (2008) notes that there are between 13,000 and 26,000 more males than females at each age from birth through to twenty. However, this number generally decreases throughout the lifespan. For those over 60 years of age, the gap between the sexes is reversed and females outnumber males by 3 to 1. The gender gap in this study is comparable (3.8:1 ratio) to the national population trend as predicted by the UK's Office of National Statistics (3:1 ratio).

This intermediate care facility was set up to accommodate for both step up and step down admissions. Yet, very few participants came from the community (n=19) with the majority (80%) off all the admission being step down admissions from two local hospitals. Over half (56.3%) of all the participants were admitted with a diagnosis of falls and suffered from three or more pre-existing ailments (63.8%).

Although the ELOS, as recorded by the TOC team and agreed upon by the service users, did not exceed 42 days, in reality the ALOS ranged from 1-105 days. Of those who remained on the unit and completed their course of rehabilitation (n=75), 66 of them (88%) had a marked improvement in their level of functioning, and a statistically significant mean change in functional ability of 24.3 was noted. Of the remaining 9 participants, 4 had no change in their Barthel index 100 scores and 5 participants declined functionally.

Out of the 85 service users who had completed their episode of care at JON, 63 (74.1%) of them returned to their own home. Even with an increased level of functioning, 49% of those discharged home required a higher level of support than that which they were admitted with. It is hypothesised that this may have been due to an inadequate care package at the time of discharge. The following quote and others similar to it that have been presented in this chapter underpinned this hypothesis:

Even though I have a care package at home the level of it [is] not sufficient and the agency not enough to help me. Before going into the hospital I went through a week of hell between the social services, care organizer and hospital, to sort out what to do for me and no one was able to come up with a care package for me. So I thought I will go into hospital and they can sort me out then, that is where JON came in.

Identification code 211

From the satisfaction questionnaires, the analysis of the seventeen questions found that on the whole the participants were happy with the care they received. They agreed that the staff did all they could to make them well again, whilst treating them with kindness, dignity and respect. Analysis of the free text revealed comments that confirmed the quantitative findings from the questionnaires. The free text comments also exposed some concern over the staff's availability, communication with each other and with service users and family members.

The findings from this chapter indicated that the majority of the service users had improved functionally, returned to their home and found the service on the whole to be '*excellent' (ID Code 235).* There was disparity between the service users' outcomes and their perception of the effectiveness of the IC being provided on this unit and the staff's views on how the unit was functioning. This difference and the results from integrating all of the data from both qualitative and quantitative data sets are the focus of the next chapter.

CHAPTER 6

TRIANGULATION OF THE FINDINGS

6.1. Introduction to the Chapter

This penultimate chapter of the thesis presents an in-depth interpretation of the findings from the triangulated data sets. By integrating the qualitative and quantitative findings, the study was able to facilitate an interpretation of the findings and present a rich description of the workings of the unit as it moved its person-centred model into practice. As stated throughout this thesis the mixed methods model used for this study is known as a current triangulation design (Creswell et al., 2003). Within this approach triangulation is viewed as a way of integrating the results in order to obtain a richer, broader picture of the case being studied - this use of triangulation allows for the integration of data sets in order to look for, and further examine convergent and divergent findings. The resulting themes that emerged from this process dominate this chapter.

6.2. Triangulating the findings

By adopting a mixed methods concurrent triangulation design this case study was able to analyse concurrently both qualitative and quantitative data sets and document the interpretations of these analyses separately. The qualitative data was able to expose what was occurring on the unit from the perspectives of the staff and service users. How they believed the unit was functioning. Concurrently, the quantitative data was able to speak to the success of meeting the service users' care outcomes and meeting the standards set by the Department of Health, such at a 6 week time frame (DH, 2001). These interpretations have been presented in detail in chapters 4 & 5. Once these separate analyses were complete, the data sets were then integrated in order to allow a more thorough picture of the unit to be exposed. The interpretation of the combined analysis is presented in this chapter.

The results of triangulating the two sets of findings indicated that a modest amount of the qualitative and quantitative data collected provided complementary findings, as was the case when the qualitative data from staff interviews identified poor communication and a mis-understanding of the unit by external sources, leading to the inappropriate admission of some service users; specifically, the admission of service users who were still too incapacitated to achieve the goals of their IC treatment plan within the time frame (ELOS) dictated by the TOC team and agreed upon by the service user.

[Referring to the local hospital trust] sending down patients at the moment that are completely inappropriate.

Identification code 83

They are not ready for home, nowhere near ready by the time they said they would be.

Identification code 111

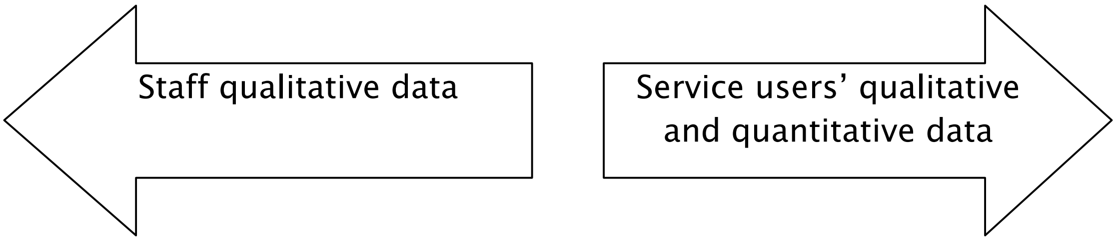
This qualitative subject matter was able to be followed up with supporting quantitative data. The data showed that the majority (71.2%) of those who had a completed data set (n=66) had an ALOS which exceeded their ELOS. Furthermore, 28.2% of these service users stayed longer than the DH's guidance of two to six weeks. Although this study did not possess the capacity to account for the reason for the increased LOS, it is known that such a finding (increased LOS) is not unique to this study. This will be discussed in detail in section 6.4. For now, this statistic is being used as an example of how the qualitative and quantitative data sets complemented one another. Even though these data complement one another, however, similarity of the data sets was not the norm for the majority of the data collected. In fact, at first glance, the qualitative and quantitative findings appeared to diverge from one another.

One example of the divergent findings is noted in section 4.5.2.1. when staff interviews indicated that the dysfunction amongst the MDT was impeding the staff's ability to provide quality care. This qualitative finding was opposite to the quantitative findings which suggested effective PCIC, such as a statistically significant change towards increased functional ability for the service users receiving care on the unit (see section 5.3.5.). Table 6.1 and 6.2 summarize the convergent and divergent data which exposed the mis-match of the findings. Appendix 14 contains a detailed version of these figures with qualitative and quantitative examples accompanying each category.

Figure 6.1 Convergent findings

Staff qualitative data	Service users' qualitative and quantitative data
The interviews indicated that poor communication with outside referring agencies resulted in inappropriate transfers.	Quantitative data indicated 47 SUs had an ALOS >ELOS. With 19 having an ALOS that exceeded the DH's imposed 6 week time frame. 1 service user died whilst being cared for on the unit and 9 were readmitted to hospital.
The interviews indicated that communication was dysfunctional within and across teams.	The interviews indicated that communication was a weakness of the care being provided on this unit.
The interviews indicated that poor communication with outside agencies resulted in service users being uninformed as to what to expect from JON.	JON's protocol stipulated all SUs were to consent in writing to an ELOS and treatment plan prior to transfer, and quantitative data indicated 9 SUs did not have this information recorded. The interviews indicated that SUs did not have a firm understanding of the unit's function and/or capabilities.
The interviews indicated that working relationships were positively viewed at an individual practitioner/carer level.	Satisfaction questionnaire and the interviews indicated SUs believed staff worked together and knew what each other were doing in order to deliver optimal care.
The interviews indicated that the physical environment was a good place to work and conducive to recovery.	The interviews concurred that the physical environment was of high quality and met with great pleasure.

Figure 6.2 Divergent findings



The interviews indicated there were many issues impeding the team from delivering quality intermediate care. They were predominantly:

- Constraints from the CSCI regulator
- Uncertainly about the vision of JON's IC unit and the model of care being provided
- Professional judgements being disregarded
- Dysfunctional within and across teams
- Insufficient equipment to provide care
- Autocratic leadership
- Fragmentation within the MDT

Quantitative data indicated that the majority of the service users on the unit received quality intermediate care, improved functionally and returned home.
The interviews indicated on the whole that SUs were satisfied with the care they received and beleived staff treated them with respect whilst meeting their intermediate care needs (e.g. assisting them to improve functionally and organizing care at home as need be).

Satisfaction questionnaire and the interviews indicated SUs believed staff worked well as a team in order to deliver optimal care.

From the findings presented in Figure 6.2, it is obvious that a great deal of the data collected did not complement itself; this was not completely unexpected. The potential that the data sets would be mis-matched during the analysis phase was taken into account when the study was developed (see section 3.5.). According to Tashakkori & Teddlie (2003), when adopting a mixed methods design, within a single study, researcher(s) must be prepared for the possibility that the qualitative and quantitative findings may diverge from one another. If this occurs the researcher(s) must first verify that those inconsistencies in the findings were not as a result of an error or oversight made in the application of the data collection or analysis, or as a consequence of the inadequacy of the applied theoretical concepts. In regard to the latter, one would presuppose the theoretical concept underlying the research focused on the data sets concurring or complementing one another (Flick, 1998). As was clearly stated in the methodology chapter (chapter 3) no such theoretical concept was at the heart of this study: understanding this unit and how it was functioning was not dependent on the results converging or diverging. Once all the data was collected, individually analysed and then triangulated, the mis-match became evident.

Within this study, a mixed methods approach was implemented in order to add depth and breadth to the methodological proceedings (Creswell, 2007). When the triangulation of the findings indicated a divergence between the data sets, in order to ensure research rigour, a methodological examination of the sampling, research instruments and the process of data collection and analysis was undertaken. The resulting inquiry clearly indicated that no mistakes were made in the application of the qualitative and qualitative methods used in the investigation.

Once the methodological soundness of the findings was reconfirmed, the results were revisited and the literature assessed. The mis-match between the findings, specifically the polarization between the views of the practitioners seeking to achieve PCIC (the functioning of the unit was problematic) and the outcomes of the service users receiving PCIC (the unit met their expectations and assisted them to become more independent), is the focus of this chapter.

The difference in the findings and the resulting use of emotional labour by the staff (see section 6.3.) in order to enable PCIC to be delivered highlighted the setbacks and the fluid participation of personnel at JON. Furthermore, the interviews exposed some of the 'gut wrenching' experiences of the staff as they progressed through their innovation journey (Van de Ven et al., 1999). Whilst tracking the innovation journey, it became apparent that there was a change to the original model. This change was detected through the study's concurrent triangulation mixed methods design.

Fundamental to the study's findings is that, by collecting and individually analysing multiple sources of data and then triangulating the data sets, the study was able to uncover the divergence that was evident in the data. A secondary literature review was then done in order to understand what was occurring on the unit. From this search it was revealed that the team was essentially a new team and in the performing stage of Tuckman's model, and that the staff used emotional labour in order to successfully implement intermediate care in this nursing home setting (see section 6.3). Had the study only sought quantitative findings the struggle the staff were going through, which ultimately led to the use of emotional labour, would have been missed. On the other hand, had the study only assessed the staff's perception and not sought to measure the service users' outcomes, the successful implementation of the model may have been missed.

6.3. Emotional labour

A secondary literature search was conducted following the data analysis and the exposure of the mis-match in the findings. This search resulted in an understanding of emotional labour and exposed how this practice method enabled the staff to deliver PCIC within a community based nursing home setting. Arlie Hochschild (1983) coined the term 'emotional labour' in her seminal work, *The Managed Heart: Commercialization of Human Feelings*. She used the term to mean the management of feeling to create a publicly observable facial and bodily display which requires a person to alter their feelings in order to present a socially acceptable outward appearance. She notes that jobs which require emotional labour have three shared characteristics:

1. Face to face or voice to voice contact with the public.

2. They require the worker to produce an emotional state in another person, e.g. gratitude, fear.

3. They allow the employer through training and supervision to exercise a degree of control over the emotional activities of the employees (Hochschild 1983).

Emotional labour has its origins in domestic care work. It is the occupational equivalent to the emotion management that occurs during 'caring' in a private environment (Smith, 1992). It was not until Hochschild made the conceptual link between care, feelings and emotions that 'emotional labour' began to permeate the public discourse.

Nursing is a historically gendered occupation which sees nurses exploring the sometimes uneasy relationship between nursing skills and innate female qualities. Within this profession, the concept of emotional labour is not new, only the term is. Within the health care domain, a key concept that overlaps with emotional labour is the concept of sentimental work. In contrast to instrumental work, sentimental work is defined by Strauss et al. (1982) as an ingredient in any kind of work where the object being worked on is sentient and reacting. Although the discourse of emotional work has only begun to permeate the health care field the roots of sentimental work go back to earlier research on nursing strategies for maintaining 'composure in the face of difficult deaths' (p. 254).

The early work on emotional labour by Hocschild (1983), and later by Smith (1992) and James (1992), has inspired a body of research that is now focused on further defining, conceptualizing and 'operationalizing' emotional labour (Smith & Gray, 2001; Glomb & Tews, 2004; Bono & Vey, 2005). Nearly two decades have elapsed since Smith (1992) applied Hochschild's work to nursing in her widely cited observational work on how student nurses are socialized into nursing. In her 2001 follow up work with nursing students, Smith sought to uncover possible changes to emotional labour based on changes in current health care policies, nursing education and methods of practice. This study concluded that nurses and students continue to see emotional labour as vital to the care they provide. Yet, due to emotional labour often being seen as a tacit and un-codified skill, it remains undervalued.

Emotional labour is instrumental in nursing and many other service-related professions yet has not received the credit it rightfully deserves (Härtel et al., 2005; McClure & Murphy, 2007). Putman and Mumby (1993) note that emotions in the context of organizations have historically been consistently devalued and marginalized. They argue that the lack of recognition is as a result of organizations having been conceptualized as rational and instrumental, with no place for emotions that have been seen as purely physiological. Putman and Mumby (1993) built upon Hochschild's (1983) earlier definition of emotional labour as a 'commodity'. This argument was supported by the concept that within an organizational setting labour is needed in the management of one's emotions. Through purposeful performance activities such as recruitment, selection, socialization and personal evaluations, organizations develop a social reality in which feelings become an instrument in achieving organizational goals (Grandey, 2000). As such, feelings are a commodity and should be recognized and remunerated.

Fineman (1993) furthers the concept of emotions as a commodity by exploring the social construction of organizations. He argues that organizations are intensely subjective and personal and that staff are 'actors', whose emotional energies are the 'social glue that will make or break organizational structures and gatherings' (p. 15). It is the extent to which the emotional management of one's feelings within a particular setting is consciously or unconsciously performed, that seems to be the current divide in the literature. Some academics state that habits and automatic routines form the ideologies which shape the various norms associated with the dos and don'ts of a particular feeling, in a particular situation. These habits or 'feeling rules' are predominantly shaped by families, schools, groups, religions and the media (Denzin, 1990, Hartel et al., 2007). Others consider employees to be consciously aware of how to perform emotionally within an organization and thus are actively involved in the construct of their reality (Van Maanen & Kunda, 1989; Smith & Gray, 2001; Hartel et al., 2007). Regardless of what ontological camp you side with, our current occupational culture sees us all having responsibility to manage our work emotions.

Within the public sector, there is a social consciousness about what feelings should be shown in what circumstances (Hochschild, 1979). According to Fineman (1993), whether or not an employee conforms to the socially acceptable expected emotional performance depends on one's feelings of failure to conform. He goes on to argue that the socially connected emotions of shame, guilt and embarrassment are the motivational factors which are central to many aspects of organizational control. The emotions associated with how others will see us motivate us to portray certain emotions in a certain way. The discomfort associated with embarrassment is enough of a motivational factor to encourage most employees to do right by the organization when dealing with patients or clients. An in-depth discussion on the moral conduct of employees is not within the remit or scope of this study. However, it is important to note that the current literature on emotions and training agendas support Fineman's views, emphasising that an individualized, but trained skilful display, of certain emotions is an essential feature of many interpersonal exchanges in organizational life (Van Maanen & Kunda, 1989; Flan, 1993; Härtel et al., 2007; Smith and Gray, 2009).

Within JON, the qualitative data suggest that there was no such training agenda for employees who were providing intermediate care at JON. However, through emotional management the staff were able to convey to service users and their families an image of a highly effective team. This image differed greatly from that which was conveyed during private, confidential, interview sessions. The following discussion focuses on how, through the use of emotional labour, the staff at JON were able to deliver PCIC that resulted in the majority of JON's service users improving functionally and returning home. As was documented in chapter 4, the qualitative date indicated that the staff were in a state of chaos, yet the quantitative data collected indicated the staff were delivering effective intermediate care. The data showed 88.0% of the service users who had a completed data set (n=75) had an improvement in their overall functional ability as indicated by their Barthel index 100 assessment (discharge score > admission score) with an overall statistically significant 24.3 point mean change towards increased functional ability. Furthermore, service users were satisfied with the care they were receiving. Out of the 59 respondents, 91.6% of them were satisfied with the amount of recovery they made during their stay on the unit, with 96.7% reporting that staff did their best to assist them in becoming more independent whilst doing all they could (96.5%) to make them well again.

The qualitative staff themes which illustrated a fragmented MDT with uncertainty surrounding individual team members' roles and responsibilities (see section 4.5.2.1., clearly illustrated a team in jeopardy. However, some of the quantitative data clearly meet the JON foundation's own predetermined success criteria; data such as the statistically significant increase in functional ability (see section 5.3.3.) for 67 (88.0%) service users who had completed data sets (n=75) in conjunction with the 63 (74.1%) service users who returned to their own home, with 5 (6.7%) returning to the nursing home they were admitted from. In addition there were the 96.7% of service users who agreed/strongly agreed that they were treated with kindness, dignity and respect (see section 5.4.).

This study suggests that the staff's use of emotional labour is responsible for the mis-match evident between the staff's perception of how they were functioning and the service users care outcomes and perceptions of the care that staff were providing. It is proposed that, through emotional labour, staff were able to overcome the dysfunction and uncertainty within the team. This resulted in the provision of effective person-centred intermediate care and an image of being a cohesive and highly effective team, although one could argue that the team did not have to 'put on' an image of being highly effective precisely because they *were* effective. According to the quantitative data, the outcomes successfully met the JON's foundation's own criteria for success. Thus, staff were doing the job they were hired to do; which was to rehabilitate service users using a person-centred approach. However, the qualitative themes clearly indicate a team that was not functioning successfully from an emotional standpoint.

Through emotional labour, the staff acquired the ability to manage their feelings of *'hanging on by the skin of our teeth' (identification code 101)* and present a socially acceptable image of their team. This resulted in comments such as '*they are a great team' (identification code 119*). It is not being proposed that the PCIC being delivered on this unit was without fault. There were clearly areas that needed to be improved upon such as communication with service users and their families (see section 4.6.1.4.(2)).

According to Hochschild (1983) a person engages in emotional labour when they attempt to alter an emotion or feeling so that it is fitting for a particular circumstance, and in order to adequately assess each circumstance appropriate emotional social guiding principles must be used. She goes on to distinguish between emotional labour and emotional work. Noting that emotional labour is the paid act of hiding one's emotions to soothe patients and emotional work is having real emotions in private circumstances. Although, as of late, some academics have begun to question Hochschild's division of emotional labour (Theodosius, 2008), what remains unquestioned in the literature on emotional labour is that social life is largely regulated by ideologies of feeling that are guided by rules or scripts and as such emotional labour shapes actions when there is a division between what one feels and the script. Emotional management allows us to alter our feelings in order to bridge that division or gap. Within JON, the gap was the difference between what the staff had anticipated (see ensuing paragraph) and what was occurring on the unit (dysfunctional team, see section 4.6.2.1(1)).

Some of the staff interviewed spoke of their expectation of re-providing services from a former community care hospital within JON's new ultra modern facility. They believed they would be providing a new, innovative approach to care which would be spearheaded by enthusiastic supportive leaders. However, they went on to say that what they were experiencing was a profound sense of miscommunication/ misunderstanding of whether or not services from a former community hospital were being re-provided. Furthermore all staff expressed uncertainty over the type of service users coming to the unit and the care to be given to them, as well as, confusion surrounding the roles and responsibilities of key players of the MDT and a sense of loss associated with the turnover of staff.

It is most isolating three months down the road... left single handedly trying to drive the vision forward.

Identification code 83

We lost the people who had the view

Identification code 801

According to Van de Ven et al. (1999) within an IJ, the fluid participation of the participants creates significant continuity problems. Moreover, other studies assessing intermediate care also noted instability with team leadership and fluid participation of intermediate care players (Griffiths et al., 2001; Barton et al., 2006; Regan et al., 2008). At JON, the inconsistent staffing of both front line workers and managers produced a sense of unrest which was further compounded by the leadership roles assumed within this journey. Specifically, the critic role was being filled by the one remaining manager (out of the original four) and the mentor and sponsor roles were left vacant. As seen in chapter 4, the staff interviews suggest that during the first year of functioning the mentor and sponsor roles had been filled by the PCT and social services managers. This changed in the second year of functioning (the year in which the study was collecting data). During year two, as a result of the restructuring of both the PCT and social services, the mentor and sponsor roles were unoccupied. This in turn, left an unbalanced power dynamic on the unit. Consequential to this was the staff feeling a sense of loss of support and questioning the vision of the unit.

The team's use of emotional labour to bridge the gap between how they felt and what they needed to portray can be best described using James' (1992) 'carework' model. This model identifies the following components of providing care:

Care = organization + physical labour + emotional labour.

James parallels emotional labour with physical labour, stating both are 'hard, skilled work requiring experience, affected by immediate conditions, external controls and subject to divisions of labour' (p. 95). Both physical and emotional labour were clearly exerted by staff working on the unit as the team attempted to craft their own model of person-centred intermediate care. The organization and physical labour that went into the intermediate care being provided on this unit was clearly referenced throughout the staff's interviews. However, the emotional labour component went undetected or at least unacknowledged. The team's ability to utilize skilled emotion management (Fineman 1993), whether intentional or subconscious, was a valuable part of the care being provided on this unit where caregivers (registered and non-registered, i.e. RN or care assistants) were using emotional labour in the accomplishment of technical tasks as well as in the creation of the correct or appropriate emotional climate. It was a new modern building, a new, innovative approach to care for the staff at JON, and ultimately an exciting time of change. Although laden with emotional turmoil, the staff conveyed (for the most part) a sense of pleasure and optimism when speaking with service users and their families. On the whole, the care outcomes met the JON Foundations predetermined success criteria. Furthermore, the majority of the qualitative date from the service users' interviews contained positive narratives such as:

They are excellent... Really there is nothing more they can do ...Everything helped me...They are so lovely here, it is a beautiful place.

Identification code 235, 233, 246

There were, however, indications from the service users' data that some of the challenges the staff were facing were affecting the care. The findings presented in chapter 5 point out that some service users were aware of the miscommunication that was occurring on the unit. With regards to the quantitative findings, data were missing due to the staff's non-compliance in notifying me of admissions/discharges and in documenting routine data. An explanation for both, the concern voiced by a few of the service users and the staff's inability to be attentive to details when recording routine daily activities, focuses on emotional labour.

The staff were using all the energy they had to simply be '*ploughing ahead' (ID code 910)* and meeting the intermediate care needs of the service users, while concurrently sustaining an emotionally, socially acceptable environment. As such, staff had little energy left to engage in any other activities. Their emotional resources were at capacity, and this labour was exhausting them emotionally and physically. By the end of the data collection period, the group was beginning to splinter.

The following quotes assist in illustrating the emotional exhaustion that was beginning to take its toll on the staff:

We are just floating now. We are like ships in the night just passing each other not really knowing what we should do or where we should go.

Identification code 111

We have always supported one another in work but now for the first time ever we have been supporting one another out of work, because we felt that additional need.

Identification code 610

Everyone is tired and now there is this no compliance from the staff as well 'I'm not doing that' or 'I'm not doing that I don't get paid enough'.

Identification code 112

The qualitative findings from staff interviews indicate that, by the end of the data collection period, emotional exhaustion was prevalent amongst staff. Conversely, this exhaustion does not account for earlier findings from the service user data which indicated that, from an early stage of the study, some of the staff's negative emotions permeated the unit and were detected by some service users and their families. One potential explanation for this is that emotional labour is not always undertaken successfully by all care givers. Although emotional labour on the unit was part of the everyday working of the team it was not effortless. At times the giving of emotional work was not always efficient either. Although often credited with being an innate female quality and inherent in work that has been historically dominated by women, the management of emotions is an acquired skill (James, 1992). Caring is not innate or natural for everyone (Smith, 1992). At JON, for the most part, due to past experiences as professionals working within a health/social care culture, staff possessed an understanding of social scripts or guidelines and were able to fit the socially acceptable emotion to the situation.

In her work with gynaecology nurses within the NHS, Bolton (2000) stresses that the management of emotions is more than just the controlling or suppression of emotions such as 'at the funeral I tried not to laugh'; rather it is the process of moulding emotions to fit a particular situation. The act of evoking and shaping emotions was illustrated throughout the staff interviews, and the energy needed to do so was beginning to wear the staff down. During the staff's final interview sessions there were comments that suggested all the effort staff were putting into carrying out PCIC may have been working against exposing how dysfunctional the team was, and their underlying need for support and encouragement. In other words, the need to have the mentor and sponsor roles filled in order to balance the critic roles that had dominated the team during their IJ.

The service users' satisfaction questionnaire and semi-structured interviews spoke about the staff's ability to display a socially acceptable image, therefore successfully masking their discontentment with the functioning of the unit. However, not all staff were encouraged by the results as displayed in the BSC. The following quote illustrated how emotional labour may not have always worked to the staff's benefit. During the last interview session, after the BSC was presented, a staff member commented on the statistic that indicated, over the preceding three month period, 96.7% of service users felt staff treated them with kindness, dignity and respect.

I am looking at that and that is pleasing, the negative of that is we've got this autocratic management- they are going to look at that and think this is pleasing we don't have to change at all.

Identification code 140

By engaging in emotional labour, staff were able to alter their feelings to fulfil the goals and expectations of the JON Foundation from a practice standpoint. This meant staff either expressed only positive opinions or managed to hide their negative opinions. Putman and Mumby (1993) argue that emotional labour is experience at its strongest when employees are asked to express emotions that contradict their inner feelings; the larger the gap the more potential stress an employee may experience. Van Maanen and Kunda (1989) note that emotional numbness and burnout frequently accompany the incongruence of felt and displayed emotions. The effects of burnout on productivity may account for why there now exists within the organizational/management field a plethora of literature on the benefits of addressing emotional labour in order to ward off the resulting burnout that can occur when emotional labour is not validated. For instance in 2006 the *Journal of Management and Organization* dedicated a full issue to emotions and coping with conflict (Jordan & Troth, 2006).

Within JON, the staff's ability to manage their emotions in a professional manner was never addressed. By the final set of staff interviews, at the end of the year-long data collection period, staff morale was at an all time low. Study participants were 'tired' from the amount of energy that was being exuded to '*put on a happy face' (ID code 103).* Management continually exhorted staff to provide person-centred care in an intermediate care unit, whilst merging three separate groups of professionals and untrained care providers. Yet, the emotional complexity inherent in caring on this unit was not taken into account. Nor was the power struggle that was occurring amongst various members of a MDT as they travelled through their innovation journey.

Whether focussing on the difference between felt emotions or displayed emotions, the qualitative data clearly indicates that emotion was at the core of the staff's reactions to their workplace situation. Although unable to identity emotional labour as the effort which was leading to their exhaustion, staff looked for recognition of how hard they were working to *'keep it all together' (ID code 071).* This lack of recognition of the labour being exerted on the unit was clear in the following quote:

> *Nobody has been praised, I would say there has been no recognition of care or improvement or anything. No one has said 'you are all doing a fab job'. To keep morale up to keep the spirits up.*
>
> *Identification code 101*

JON benefited from the emotional labour being performed by the members of the team. Yet management did not openly acknowledge this labour nor did anyone seek assistance in helping to guide and nourish it. JON's inability to recognize the need for support of emotional labour is all too common within the health care profession. Within the literature, there is call for emotional labour to be supported educationally and organizationally (Smith & Gray, 2001a; Gray & Smith, 2009). For years pioneers in the field of emotional labour such as Hochschild (2003), Gray (2002) and Smith (1992) have been calling for the organization and appreciation of emotion within the workplace. Within nursing specifically, at the turn of the century, Smith and Gray (2001) noted emotional labour was crucial in sustaining the 'culture of care that is the building block of nursing in the NHS' (p. 48). To this day theorists continue to plead for emotional labour to receive the recognition it deserves (Gray 2009).

6.4. The challenges of implementing a person-centred intermediate care model

The model of care being implemented at JON was a philosophical model that focused on providing person-centred intermediate care within a nursing home setting. The JON Foundation prides itself on its ability to provide person-centred care. When developing an intermediate care unit, the Foundation naturally used the NSF document as guidance (DH 2001). Within this document it is clearly stated that regardless of setting, all older people should be treated in a person-centered manner. Therefore, it calls into question why there was such difficulty at JON implementing person-centred intermediate care, and why the staff needed to use a significant amount of emotional labour in order to allow this to happen. The following section provides a possible explanation for this challenge based on the data collected from the study and the information retrieved from the literature searches.

The triangulation of the data sets clearly exposed the challenges of implementing intermediate care within a nursing home setting under CSCI regulations. When staff/ informants were asked what model of intermediate care they were using at JON, they were unable to identify a theoretical model; only that it was person-centred (see section 4.6.1.5(2)). This finding is not uncommon in the field of gerontological nursing. It has been noted that when providing person-centred care nurses experienced great difficulties in articulating what knowledge, skills and expertise make up their daily practice, and how this practice shapes patient care (Nolan et al., 2004; McCormack, 2004). At JON, compounding the staff's difficulty in identifying a model was the underlying reality that the model being implemented was ideologically not theoretically based. As was detailed in chapter 2, currently within the literature on intermediate care, there does not exist a theoretical model that details person-centred intermediate care within a nursing home setting.

The model being implemented at JON was based on the JON Foundation's ideological model which amalgamated the NSF's standard two and three (DH 2001). The National Service Framework (NSF) for Older People was published in March 2001 and consists of a set of national standards and service models of care for older people's health and social care services. This document clearly references the importance of involving older people and their careers in the planning and implementation of health and social care and contains a number of cross-cutting themes. Of the eight standards presented in this document, five encompass the following broad issues: eliminating age discrimination, person-centred care, intermediate care, and general hospital care and health promotion. The other three standards are: mental health, stroke and falls. There is also a medicines supplement that provides directives for medicine management and poly pharmacy (DH, 2001).

In summary, the eight standards are as follows. Standard One: rooting out age discrimination, corresponds with government's political agenda of fair access based on need and focuses on the desire to reduce stigma, as being old and mentally ill is seen as a 'double whammy' (Baldwin, 2003). Standard Two: person-centred care, contains important principles such as integrated commissioning of services and standards for dignified care at the end of life and introduces the single assessment process. This was designed to stop older people having repetitive senseless assessments (Wilson et al., 2005). Standard Three: intermediate care, was introduced in the 'National Plan' in 1999 and aims to provide newly-commissioned, short-term alternatives to hospital care, either in the hospital or in the community, and is the only standard that was supported by new funding (see chapter 2). Standard Four: general hospital care focuses on models of acute, continuing and rehabilitative care. Standard Five: stroke, speaks to care of people with strokes and delineates clear clinical pathways and service models. Standard Six: falls, addresses falls and provides a broad range of preventive and rehabilitative measures. Standard Seven: mental health in older people, contains mental health pathways. Lastly, Standard Eight: the promotion of health and active life in older age provides an overview of healthy living for later life (DH, 2001; Baldwin, 2003).

One could argue that all eight standards apply to JON as it is a facility that is predominantly serving the older population and is mandated by CSIS. However, it is standards two and three that are the focus of the following discussion which addresses the PCIC model that evolved at JON during the unit's first two years of functioning.

The exact wording of standards two and three are as follows:

> STANDARD 2
>
> NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including equipment and continence services (DH 2001p, 23)
>
> STANDARD 3
>
> Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospitalization admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long term residential care (DH 2001, 41).

When scrutinizing the aims of both of these standards and the aims and goals of JON's IC unit, it is apparent that the model of care being implemented on the unit was underpinned by person-centred care and intermediate care. JON's MDT, under the regulations of CSIS, was providing personalized rehabilitation in a timely manner to older people. They were assisting older people in their early discharge from hospital (for the service users who were transferred from a hospital setting as step down) and in preventing hospitalization or untimely admission to residential care (for the step up admissions).

Even though a building block of the JON foundation, and one of the underlying principles of intermediate care, is person-centredness based on enabling the data from staff interviews illustrated the difficulties that occurred at the practice level when integrating these two standards. Staff had identified CSIS and the 'person-centred approach' to care, as impeding the intermediate care they were attempting to give. The context in which these comments were made indicated that staff were not having difficulties with all aspects of person-centred care. Rather they were experiencing difficulties with allowing service users to make informed choices regarding aspects of their rehabilitation plan, specifically, in situations where a service user was not in agreement with actively taking part in rehabilitation, such as walking to the dining hall. The following comment highlights the concern:

You can't force them to walk there when you are supposed to be person-centred.

Identification code 801

According to the therapists working on the unit, resistance was seldom encountered when service users were asked to walk up and down the halls with the therapist, as part of their therapy. It is conceivable that staff had more difficulty with the informed aspect of choice than they realized. Perhaps the service users would have been more compliant in walking down the hall to the dining room had they been informed that this was part of their rehabilitation plan. Once again this hypothesis has not been tested but is one potential explanation for the difficulties staff were experiencing whilst attempting to craft their person-centred intermediate care model.

Staff expressed a desire to provide PCIC. The difficulty was not in them wanting to provide this form of care, rather, in the lack of practical guidance necessary to do so, specifically, within a nursing home setting, under nursing home regulations, using nursing home paperwork. Compounding this was the lack of service user education on what to expect from IC within a nursing home setting. This lack of education, or perhaps miscommunication, resulted in confusion on behalf of some of the service users and their family members. For instance, staff made a conscious effort to encourage independence and have service users do for themselves as much as they could. Some service users, interpreted this form of care as staff's unwillingness to provide the care needed. The following two quotes illustrate this dichotomy of the staff and service users' perception of PCIC being delivered on the unit.

The more independent you are the more they left me alone. I don't criticise because I know they are sort of rushed. I am used to the district nurses at home, they are efficient. But here I am left to do it on my own. It must be not enough staff; they are occupied with other people. There is not enough nurses around.

Identification code 233

[Referring to the service users and the staff] we are coming at it from different angles. The relatives and the patients are hearing a different thing from what they were being told [in hospital]. 'Oh JON is a nursing home they will take good care of you'...they didn't know they had to work when they got here... but we can't always 'do for them' or they will never get better....it is person-centred even if I am forcing them to do it which is person-centred cause it will make them better...there is no one at home that is going to do it for them.

Identification codes 111, 112, 801

According to the CEO of the JON Foundation, rehabilitation should be in all aspects of care, 'from brushing one's own hair to walking to the dining hall, every aspect of care should have a rehabilitation focus' (personal communication, CEO, 2007). An encouraging development nearer to the end of the data collection period, came with the announcement of a particular programme (the name of which is withheld to maintain confidentiality) that focused on encouraging rehabilitation by identifying an area of daily living that could be enhanced through incremental improvements. Essentially the programme focused on encouraging service users to identify one aspect of their current functioning that they would like to improve upon. A plan focusing on how to achieve this goal would be developed in collaboration with staff. This was in addition to any previously developed rehabilitation plans that were currently being implemented. This programme gave the staff a concrete example to focus on, and was an exceptional example of the praxis of PCIC that was happening at JON.

From the findings, it is clear that staff were aware of the need to provide person-centred care. Although person-centredenss is a building block of IC, so too is receiving rehabilitation in order improve functionally and return home within a short time frame. The findings from this study indicate that not all service users improved functionally, 5 having decreased functionally, 1 having died, 9 requiring re-hospitalization and 19 staying longer than the DH's guidelines of two to six weeks. Four service users did not have a change in functional status, their admitting level of functioning was relatively high to begin with ranging from 66– 88 on the BI 100.

When assessing the data separately, there is evidence that the team was providing person-centered care but having problems implementing intermediate care, findings such as staff treating service users with dignity, kindness and respect which are all indicative of person-centred care. In regards to IC some of the findings (see preceding paragraph) indicate less than effective IC. Whilst still other findings indicate that the majority of the service users did improve functionally whilst being cared for on the unit and were discharged back to their own home. However, once the data was triangulated the true workings of the unit were exposed and it became clear that, through the use of emotional labour, the team at JON was able to successfully deliver PCIC.

When consulting the literature, it became evident that some of the findings within this study which called into question the successful implementation of IC were not unique to JON. Other IC studies have questioned the effectiveness of intermediate care, querying if improvement in functioning was truly a positive therapeutic effect of IC or was 'simply a product of an increased stay' (Griffiths et al., 2009, p.11). These findings call into question if staff at JON were delivering intermediate care or were simply delivering person-centred care to service users who were admitted into an intermediate care facility.

Recent IC research has noted 'significant and important gains in functioning' for service users of intermediate care, while concurrently questioning the appropriateness of some of those being admitted into the service (Kaambwa et al., 2008, p. 579). These findings are supported in this study by the numerous staff comments that have highlighted the potential for inappropriate admission of service users to this unit.

The diversity of service provision in intermediate care is remarkable and this diversity has been hailed by the DH as adding strength to the service. It has allowed institutions to adapt the service to meet the needs of individuals in their community (DH, 2002). However, academics have argued that this diversity has also led to 'confusion and fragmentation' (Young & Stevenson, 2006; Martin et al., 2007; Regan et al., 2008). Even though the manner in which the service has been delivered in various communities differs, the aims of intermediate care remain unwavering. The range of services that come underneath the intermediate care umbrella are meant to prevent unnecessary hospital admissions, facilitate early discharge and reduce unnecessarily/premature admission into long term care facilities (DH 2001). Even though the aims are clear, the praxis of intermediate care has resulted in different intermediate care units/facilities having their own entry criteria. It has been suggested that these differing entrance requirements may be partially responsible for the inappropriate admissions to intermediate care that have been noted in several research studies (Carpenter et al., 2005; Young & Stevenson, 2006; Barton et al., 2006; Martin et al., 2007). The inappropriate use of intermediate care beds has resulted in some practitioners and academics questioning if intermediate care is being dominated by the acute care agenda, an agenda that focuses on freeing up beds vice working 'at the pace of individual elderly people and finding the right environment to maximize their recovery' (Regan et al., 2008, p. 637).

As stated in chapter 4 (see section 4.4.5.) JON had their own admission criteria and these criteria were based on the nationally accepted NSF's aims for intermediate care (DH, 2000, DH, 2001). However, some of the quantitative data from this study bring into question if these admission criteria were being followed by the referring agencies. From the inception of the unit, there was a TOC team in place at the two local hospitals to educate colleagues in secondary care about the unit's capabilities, although staff continued to voice concern over service users being inappropriately or prematurely transferred to the unit from these referring bodies. Quantitative data noted that 5 service users had declined functionally during their stay, 4 had no improvement in their functional ability, 7 had a change to residential status, 9 were re-admitted to hospital and 1 patient died. In addition, the majority (71.2%) of service users stayed longer than their estimated length of stay and a sizeable minority (28.8%) stayed longer than six weeks, the DH's guidance for intermediate care length of stay (DH, 2000, DH, 2001). These data call into question the appropriateness of some admissions to this unit, as well as whether or not the care being provided on this unit was effectively rehabilitating individuals and getting them back to their own home (as stipulated by the aims of this service and by JON Foundation's criteria for success).

There are many components to delivering effective care. Recognizing this the JON Foundation, as seen in section 3.7.2., identified that for them as an organization, value for money was measured on the basis of whether or not the service user received the kind of care they had anticipated receiving whilst being cared for on the unit (person communication, CEO, 2007). In one particular discharge, even though the service user was being transferred to a long term care facility, the service was doing what it was meant to do, according to the JON foundation. Prior to being admitted to the unit, the service user was not coping at home and wanted to transfer into a long term care facility. A fall resulted in the service user being admitted into hospital. This ultimately led to their admission to JON.

I feel stronger in a sense. I have so many other things wrong with me that I can't walk properly, my back spinal problems; I have discovered that... I can't cope at home. I know I can't cope...for the best...I am going into a home.

Identification code 237

This service user did not return home; that was not their wish in the first place. The NSF for older people states that intermediate care should be an option when long term care is being considered (DH, 2001). In this case, that is exactly what occurred. The service user wanted to go into long term care, whilst at JON, received rehabilitation, 'felt stronger' and at discharge was transferred into a long term care facility of their choosing. Of particular note in this situation, prior to being admitted into this long term care facility, this service user, accompanied by the staff OT (who also organized the outing), was afforded the opportunity to tour two different facilities that they were considering as a possible home. The goal of intermediate care is not to avoid long term placement 'at all costs'. Rather, it is to ensure those being placed in long term care are suited for their change in residential status, ensuring decisions are made based on need not on a lack of resources and the need to vacate a hospital bed (DH, 2000, DH, 2001). This is a fine example of PCIC being provided on this unit.

The use of a mixed methods approach to data collection gave the study the strength to compare this quantitative finding with a qualitative explanation that differed from what the data, at first, suggested. Similarly, it was explained during one discharge interview that a service user was not going home but rather was going to their daughter's home. The transfer to a temporary location in a family member's home was at the service user and their family's request. This was being done until the proper equipment and renovations could be made to the service user's home in order to ensure their safety upon returning home. At the time of the six week follow up, this service user had returned home. The other residents' discharge interviews did not contain sufficient detail to address the specific cause of their underlying decreased mobility, change in residential status, readmission to hospital or death.

The reasons behind the remaining discharge locations (n=21) (i.e. change to residential status and re-admission to hospital) and the death of the service user are not known. However, what is known and is documented quantitatively and qualitatively, is that JON was reliant on the local hospital trusts and community TOC teams to fill their beds. Those referred from these TOC and admitted to the unit were not always appropriate candidates for intermediate care. This is evident in the following narrative:

They're not ready to be admitted to the unit and [the service users are] staying much longer than the transferring teams tells us they will be.

Identification code 101

We're told they [service users] seem to be fine and they're obviously well demented [when they arrive on the unit].

Identification code 103

The care outcomes focusing on in-patient mortality and change to residential status are not unique to JON (Young et al., 2005; Griffiths et al., 2009). Other intermediate care studies have also reported similar findings in a minority of their participants, such as Young et al. (2005) who noted 9% and 7% respectively. The exact reasons for these outcomes have yet to be fully researched, and one could question if ethically they ever could be. Therefore one is left to make an educated guess based on all the evidence taken into context. At JON it is hypothesized that some of these participants (n=22) may have been inappropriately admitted. This hypothesis is based on the numerous staff comments that complement the one above. These quotes draw attention to the issue of service users being admitted to JON who were confused and or physically incapable of engaging in rehabilitative activities. Increased LOS has been a common finding of other intermediate care studies (Griffiths et al., 2009). However, it is hypothesised, for this study, based on the supporting qualitative data, that for the 71.2% of service users who stayed longer than anticipated at JON's IC unit, their increased LOS had more to do with miscommunication/ misunderstanding by outside agencies of JON's IC unit's function and capabilities than it did about the staff's ability to effectively deliver PCIC. Similarly, Carpenter et al. (2005) found that, in the three intermediate care units/facilities they studied, the LOS exceeded six weeks (ranged from 17.1% to 31.7%). They also questioned whether external factors had an influence on this LOS.

A further finding for this study is that the majority of SUs discharged required an increased care package compared to that which they had in place prior to admission. There are several ways in which this finding can be interpreted. Perhaps the care on the unit was not sufficient to allow service users to independently function at home. An opposing view is that the care packages SUs were receiving at home prior to admission were insufficient. Recognizing this, JON provided diligent discharge planning and organized appropriate care packages for all SUs requiring them. The latter was the case for some SUs who commented during their semi-structured interviews that prior to admission they had insufficient support at home. According to one SU, insufficient care at home prior to admission, was one of the reasons they were admitted into JON in the first place. An important part of care on this unit was to ensure that, upon discharge, sufficient social and health care packages were in place. Although the data indicated that the majority of the service users did have their discharge care packages set up for them, the effectiveness of the level of discharge care is not known. Due to the design of the study (i.e. no control group) and the lack of follow-up data, the study did not possess the ability to assess the reason for the increased care packages nor whether or not they were sufficient for the SUs upon returning home. Further limitations of this study will be discussed in section 7.4.

6.5. Summary of the chapter

When discussing the findings from any study it is imperative to go back to the original research question and assess if the study answered the research question and if not what impeded this from happening. The question asked of this data was: What does a community based nursing home intermediate care model that seeks to integrate health and social services, voluntary and public sectors, look like and what are the key elements of its success? Through the use of thick description, summaries, tables, graphs and quotes, this study answered the research question by detailing within this chapter and in chapters 4 and 5 what the model of intermediate care being delivered at JON looked like; what the unit itself was like; what the staff delivering the care were like, and finally, what the service users receiving the care were like. The manner in which the model of care has been presented (ranging from the admission criteria to the innovation journey one team underwent whilst delivering it), allows for the replication (or not) of the model, or any part thereof, elsewhere if another team or organization choose to do so.

As for the model's key elements of success, it must be reiterated that the measurement of this model's success was based on the founding/funding organization's own predetermined success criteria. Therefore, it is concluded that due to staff's use of emotional labour JON's PCIC model was being successfully implemented, albeit with setbacks, mistakes and challenges along the way, just as one would expect from undertaking an innovation journey (Van de Ven et al., 1999).

It has been deduced from the data collected throughout this study, that during the first two years of functioning, the innovation journey that the team at JON undertook was fraught with setbacks and mistakes that are commonplace in most innovation journeys. Unique to JON and fundamental to the study's findings is that by collecting and individually analysing multiple sources of data and then triangulating the data sets, the study was able to uncover the staff's need to use emotional labour in order to successfully implement intermediate care in this nursing home setting.

CHAPTER 7

CONCLUSION AND IMPLICATIONS FOR HEALTH CARE

7.1. Introduction to the chapter

This study was conceived in response to one organization's desire to evaluate its success in reconfiguring services in order to best meet the needs of a segment of England's ageing population. Specifically, it was conceived to track JON's progress whilst it developed and implemented its own model of person-centred intermediate care. The requirements for the study were straightforward and open. Tell us what is working and what is not, so we can praise what we are doing well, and fix what needs improving upon (person communication, CEO, 2007). The methodology was left to be driven and decided upon by the previous research into intermediate care and by existing gaps in knowledge.

The first part of this chapter discusses this study's contribution to knowledge and practice. The later part of the chapter presents the strength and weaknesses of this approach whilst incorporating retrospective considerations. The chapter brings the thesis to a close by addressing the implications of this study's findings for current health care and making recommendations for future research.

7.2. The contribution of this study to knowledge and practice

7.2.1. The study's contribution to knowledge

Every older person should be afforded the opportunity to be in charge of their own destiny whether they choose to remain in their own home or move into residential care; the choice should be theirs to make, not as a result of insufficiencies in the health care system (Philp, 2002). Research has stressed the importance of older people having their say in the care they receive. England has responded to this evidence by recognizing older people's right to choice and to be treated as individuals with dignity and respect while being free of discrimination in choosing the best service, at the most convenient place, by the most appropriate professionals (Nolan et al., 2004; DH, 2001). Larger government bodies, such as the Department of Health, have set out guidelines that will enable this 'right to choose' to happen. However, the implementation of this is being achieved through the innovations of smaller private and public groups, and organizations that reconfigure these services whilst converting theory into practice in order to best meet the needs of their clientele once they have decided to seek care outside of their home. The JON Foundation is one such organization. It has attempted to address the needs of England's ageing population by implementing a person-centred approach to the delivery of intermediate care within its nursing home facility.

Research on older people's right to choose and the UK health authorities' policies and procedures have all pointed towards 'getting service right' for older people (Philp, 2002, p. 24) (DH, 1997; 2000b; 2001; Nolan et al., 2004). Yet, within the literature, there remains a lack of supporting evidence on the praxis of PCIC. This is of particular importance within nursing home settings where structurally, the philosophy of 'doing for' contradicts the potential effectiveness of the rehabilitation ethos of intermediate care (Young, 2009).

A final review of the literature conducted during November 2010– February 2011 revealed that within the UK there has been no published work focusing specifically on practical examples of how to implement PCIC within a nursing home setting. The findings from this study's final review were supported by a recent Cochrane Review on the effectiveness of intermediate care in nursing-led in-patient units (Griffiths, 2009). This study has endeavoured to fill this gap in knowledge by using a mixed methods approach to asking the same question of multiple sources of data. This was done in order to describe in detail the innovation journey that a nursing home facility in partnership with local PCT and social services undertook as they attempted to incorporate person-centredness into their own model of intermediate care, at the same time detailing the emotional labour needed to implement PCIC within this nursing home facility. The concurrent triangulation mixed method design chosen for this study allowed these findings to be reached, whereas a single method study would have missed out on the mis-match that occurred within the data sets that allowed the use of emotional labour to be exposed and detailed.

This study contributes to the field or research and to the practice of intermediate care by providing a practical example of the challenges and achievements of one nursing home MDT as they implemented a person-centred model of intermediate care under nursing home regulations. It also describes how emotional labour was needed in order to successfully meet the intermediate care needs of the service users being admitted to the unit. Simultaneously, the research has reinforced the benefits of using a mixed methods approach to studying this multifaceted service. Additionally, within the larger context of integrated services, the study provides an example of positive collaborative practice between health and social care professionals partnering to provide intermediate care.

7.2.2. The study's contribution to practice

This study has implications for students and practitioners in the field of applied gerontology who want to make a positive contribution to the care of the older person. Health care practitioners and carers need to understand how their everyday interactions can be used to influence ways that make a positive difference in the lives of service users. There is only a modest amount of systematic work that analyses the dynamics and impact that a cultural change can have at the individual and team level when practitioners attempt to craft a new event into an effective working model. This study adds to this body of knowledge by presenting a chronological account of the innovation journey that one multidisciplinary team underwent as they crafted their own unique model of intermediate care. Further descriptive work is still needed to focus on person-centred intermediate care practices which build upon this study. Expanding upon this knowledge will assist practitioners and carers in the praxis of intermediate care, whilst helping them to appreciate and understand their involvement in developing this new level of care. Section 7.4. focuses on these and other research recommendations that have come out of this study.

7.3. The study’s limitations

The single mixed methods case study design chosen for this study, although deemed to be the best possible ‘fit’ for this particular project, is not without limitations. The use of a mixed methods design has not eliminated the problems inherent in each separate method nor has it provided ‘proof’ or ‘objective truth’ to one method using the other (Creswell et al., 2003). Rather, the implementation of a concurrent triangulation mixed methods design has added breadth and depth to the study. This design enriched the research by looking at the case from different perspectives, in order to understand the comprehensiveness of the data collected. As noted by Tashakkori & Teddlie (2003) it requires a great deal of skill and rigour to study adequately an occurrence using two separate methods; and comparing the results from two analyses using data of different forms can prove to be difficult. Such was the case in this study. Limitations of the study arose from both qualitative and quantitative aspects of the study as well as from areas that were independent of the methodology chosen, such as limitations with sampling. All limitations will be discussed in detail in this section.

7.3.1. Sampling

There were four sampling limitations to this study. They were: a smaller than anticipated sample size; lack of a multicultural perspective; lack of a medical perspective; and lack of a voluntary perspective. Although some of these limitations have been pointed out throughout the study, they will now be discussed in detail. The anticipated sample size for this study was 118. This was based on a power calculation that would afford the study the ability to assess a statistically significant change in the Barthel index 100 scores. At the end of data collection only 94 service users had taken part in this study. This number was further reduced for many of the outcomes because, at the time data collection ceased, nine service users were still on the unit receiving care, nine service users had been re-admitted into the hospital and one service user died on the unit. Furthermore, due to missing data (i.e. not recorded) some variables had an even smaller number of respondents. Therefore, many of the findings reflect the outcomes and opinions (i.e. satisfaction questionnaire) of a portion of what overall was a smaller than anticipated sample size.

It is important to point out, however, that this smaller than anticipated sample size was still able to expose a statistically significant increase in Barthel index 100 scores, albeit for a smaller group of service users. Also, this small sample size was able to support other studies (that had larger sample sizes) that noted similar trends, such as service users being inappropriately placed in intermediate care units in order to free up hospital beds. The study's small sample size manifested the phenomenon intensely and allowed for an understanding of this case with regards to its context, complexity and entirety, however the small size was, never the less, a limitation of this study.

The study did not seek the medical staff's input into how the unit was functioning. The exclusion of a medical perspective may be interpreted as representing a view that places increased weight on the nursing/therapists perspective with regards to this level of care, a level of care, which has historically been predominantly delivered on units/facilities that were run by non-medical staff i.e. NLUs. As previously noted, the exclusion of the medical staff was in keeping with the funding body's wishes to present a therapist/nursing/carer perspective. Although some studies clearly acknowledge and address the involvement and perspectives of the consultant geriatricians within the MDT (Wilson & Parker, 2003; Regan et al., 2008), this study did not and is one limitation of this study's findings.

It is acknowledged that this sample was biased towards English-speaking caucasians associated with JON's geographical location. Conclusions can only be drawn from the predominantly English-speaking caucasian sample of participants admitted to the unit from August 2007 until July 2008, as the study only addressed how intermediate care was used by, and its effects on, an English-speaking caucasian sample. Thus a lack of a multicultural representation within the service user sample is another limitation of this study.

The final limitation of the sample chosen focuses on the exclusion of the volunteer group on the unit. The JON Foundation as a whole has a strong working relationship with the voluntary sector, and many of the services offered within the larger complex of JON were provided by volunteers. However, this group was purposely excluded from the sample. Throughout the life of the study, the role of volunteers on the intermediate care unit was being developed and expanded upon. At the time of recruitment, the only service provided on the unit by the volunteers was that of making and distributing tea at various times throughout the day. Because of this, the volunteers were not included in the staff/informant sample. The delivery of intermediate care services is dependent not only on a partnership between the NHS Trusts and the local authorities but also on other working relationships, such as the private sector and voluntary agencies (Manthorpe, 2006). As such the lack of a voluntary perspective is a limitation of this study.

7.3.2. Acquiescence

The tendency to agree (acquiescence) and the tendency to give the socially desirable response (social desirability) have plagued developers of satisfaction questionnaires for years and are arguably the two most studied response styles in the literature (Phillips & Clancy, 1970; Calsyn & Winter, 1999). Social desirability reflects the tendency of individuals to deny socially undesirable traits and to admit to socially desirable ones. Acquiescence reflects the tendency to agree (or disagree) to items independent of their content. According to Ross and Mirowsky (1984), claiming socially desirable traits and acquiescing are image management techniques. They found that when survey respondents were asked if they had a certain psychological symptom some said ‘yes’ not because they had the symptom but rather because they were inclined to acquiesce. Respondents who find themselves in relatively powerless positions, as well as those whose public image and the ability to ‘put on a good face’ are of the utmost importance, are likely to display these response biases; these tendencies also increase in older people (Ross & Mirowsky, 1984). As older people are the main recipients of intermediate care services and as such made up the sample for this study it must be acknowledged that biases may have affected the participants’ responses.

Acquiescence is contradictory to the concept of shared decision making which is a core building block of patient-centred care (DH, 2001). Taking into account the theories of response biases and knowing that these tendencies could have been occurring on a unit that focused on patient-centred care is alarming, but not unlikely (Carpenter et al., 2005; Barton et al., 2006; Griffiths et al., 2009). Our present health care culture is dominated by talk of the autonomous patient, patient-centredness and active patient idioms (McCormack, 2004; DH, 2006). One of the underlying principles of intermediate care itself is person–centred care based on an enabling approach (DH, 2001; Young and Stevenson, 2006). That being said, the fact remains that our current older population were born, raised and lived most of their lives in a society that was dependent on one’s public image and placed greater value on propriety, respect and proper appearance, and as such their tendency to acquiesce is far greater than that for younger patients (Ross & Mirowsky, 1984; Coulter et al., 1999).

The socio-demographic position the service users of this unit were in was indicative of those who are more likely to give socially-approved responses and to acquiesce. The satisfaction questionnaire implemented in this study provided a place for free text and the majority of the free text comments in this study supported the responses of the questionnaires. However, the study would be remiss if it did not acknowledge that the responses may have been more suggestive of response styles than of the actual care being provided on the unit.

7.3.3. Tools used to measure JON's success

Within this study, the tools used to measure JON's success are not without limitations. The potential for acquiescence, when using satisfaction questionnaires with older people, has been addresses in section 7.3.2. Further limitations of this questionnaire and of the Barthel index 100 are discussed in this section.

7.3.3.1. Satisfaction questionnaire

The satisfaction questionnaire used to assess JON's success was deemed suitable for this study. The potential for acquiescence was acknowledged, and steps were taken to try and counterbalance its potential effect (e.g. allowing for free text and semi-structured interviews). One of the limitations of this tool was not with the questionnaire itself; rather it is with the way in which the questionnaire's results are presented in this study. The presentation of the statistics from the questionnaires predominantly focused on the percentage of service users who agreed/strongly agreed. This leaves the reader to conclude the percentages of service users who disagree/strongly disagree. However, this questionnaire also included a section for 'don't know'. The percentage of service users who agreed/strongly agreed was not always directly proportional to the number of service users who disagreed/strongly disagreed. This was a result of a sizeable percentage of service users who responded with 'don't know' throughout the questionnaire. The 'don't know' category had a response rate ranging from 0 to as high as 33.9%. The highest percentage (33.9%) being for the question 'the service finished providing care for me too early' which was also noted by Barton et al. (2006) to be of concern for the participants in their study.

The following is the free text comment that accompanied one of the service users who chose ‘don’t know’ for this question:

> *I don’t know [referring to being ready for home]... I am prepared to give it a try. I won’t know if I am prepared until I get home really, won’t know if it is effective until I get home.*
>
> *Identification code 260*

This narrative confirms that a response of ‘don’t know’ does not necessarily indicate a fault of the model or inability to practice person-centred care.

7.3.3.2 Barthel index 100

A further limitation of the study is its use of the Barthel index 100 as the sole quantitative measure of independence. At this point, it is prudent to reconfirm that when the Barthel index 100 was chosen as a measure of physical activity/ rehabilitation its validity, reliability and sensitivity were assessed and found to be satisfactory. It was acknowledged during the study’s developmental stage that, although not without limitations (e.g. inability to measure small changes and ceiling effect), the tool had been used in other IC research (Griffiths et al., 2000; Steiner, 2001; Griffiths, 2002; Young et al., 2005; Kaambwa et al., 2008). Given its widespread use, the tool was implemented within this study, and a statistically significant increase in functional ability was found. However, there are limitations to this measurement. Specifically:

a. The inability of the tool to measure small changes

b. The tool’s low ceiling effect

c. The lack of a control group on which to compare these findings.

The tool’s inability to measure small changes and its low ceiling effect means that patients with a high score may still be unable to engage in some of their usual activities, which indicate independence for them, such as cooking, shopping for themselves, et cetera (Wade & Collin, 1988). Therefore, although the study can conclude that the majority of service users were more functionally independent than they were upon admission to JON, there is no record of how this discharge level of independence compared to how they were prior to their current episode of care (i.e.

going into hospital in the first place). Nor does it speak to the service user's ability to care for themselves independently upon discharge from the unit. That being said, for those who improved well enough to function independently in their own home, the extent to which they improved beyond this point was not a measure of success for this unit, during this study, according to the JON foundation's predetermined success criteria.

The findings from the BI 100 indicate that a statistically significant positive change in functional ability was measured. So too was a notable increased length of stay. Compounding this is a potential measurement bias for the BI 100 resulting from some of the non-responders, specifically the one service user who died and the nine service users who were admitted to hospital, these non-responder participants being more than likely to have deteriorated functionally. Furthermore, the majority of the sample stayed longer than their ELOS and with an increased LOS you would expect improvement over time (Carpenter et al., 2005; Griffiths et al., 2009). Therefore, taken in context it must be noted that due to the lack of a control group within this study, natural recovery over time and the absence of any other functional assessments the BI 100 results could be a result of a lengthy stay, which in 28.8% of the cases exceeded the maximum.

7.3.4. The lack of a control group

One of the limitations of this sort of study was the lack of a control group on which to compare findings. Due to the nature of the study, a single descriptive case study and the ethics of withholding or manipulating treatment from the service users entering this facility, a control group was not part of the study's design. Therefore, there was no group to provide a baseline performance with which to compare the intermediate care provided at JON.

7.4. Reflections on the study

7.4.1. The study design

As stated in chapter 2, when deciding on a research design, a case study was the funder's preferred design; the choice of data collection and analysis methods were at my discretion. In retrospect, I believe a case study design, whether specified or not, was the most appropriate design for this research. Initially during the developmental phase, had I been an employee of the facility, action research would have been considered as a means of evaluating and altering practice to best meet the needs of the participants. However, as it stood after conducting this research the use of a case study was the best possible fit for this study in keeping with the time frame.

The drive for using a mixed methods approach to data collection and analysis came from the need to address the research question and from personal, professional and academic experiences.

7.4.1.1. Personal

We are all born into a world of meaning bestowed upon us by culture. People engage in their world and make sense of their surroundings based on their history and social perspectives (Crotty's, 1998). Thus, meanings are constructed by human beings as they engage with the world they are interpreting. A study needs to be designed based on answering research questions. Research questions need to be driven by current literature that encompasses the topic of interest and gaps in research within this literature; literature that is interpreted by the reader. Some may look at the body of literature that focuses on intermediate care and see a lack of RCTs; others may see a lack of descriptive accounts. I saw a lack of a mixed methods account of the praxis of intermediate care. Specifically a lack of a mixed methods account of the journey a unit can make whilst attempting to convert theory into practice within the field of person-centred intermediate care.

Intermediate care is a complex phenomenon with many areas to be studied. Like other researchers, I could have decided to focus on a quantitative aspect of the service, such as service user satisfaction or care outcomes. As stated, the funding body wanted an evaluation of their intermediate care service; exactly how this was done was left to me to negotiate. Answering either of these quantitative questions could have provided new knowledge to the research field by contributing a unique perspective. On the other hand, I could have focused strictly on a qualitative approach and described the staff's perceptions of implementing intermediate care within a nursing home setting and how the service within this facility evolved, once again, a unique contribution to the current knowledge base surrounding nursing home intermediate care. Although research questions are driven by the literature, they are also, I believe, driven by what questions a researcher/funder believes are in need of answering. I tend to use both exploratory and confirmatory questions, needing to know if something worked and if so why or why not. JON's worldview mimicked my own and therefore, the question asked of this study had both exploratory and confirmatory elements to it.

The study sought to find out if the service users were satisfied with the care they received at JON and if so what they were satisfied with. This study was based on the lack of a mixed methods approached to intermediate care within a nursing home setting and also on my personal belief, and that of the funders, that such an approach was not only warranted but valid to gaining an understanding of the service users' perspectives. Others may not agree with this; however, this is why this discussion is titled personal and the following is professional and academic.

7.4.1.2. Professional

In my professional capacity as a nurse, my health care career has exposed me to the need to answer both exploratory and confirmatory questions from both a qualitative and quantitative approach. Nursing is both an art and science. As such it requires both qualitative and quantitative approaches to care. Thus, a mixed methods approach provided a way of addressing both questions and presenting the findings in both a quantitative and qualitative manner.

7.4.1.3. Academic

Reflecting on this study, it is again confirmed that the use of a mixed methods approach within the case study was the best possible way to answer the research question. Combining methods within a case study was laborious as it required knowledge of qualitative, quantitative and mixed methods methodology. Although labour intensive, however, the use of this method strengthened the credibility of the research findings, increased the validity of the data and provided a means of triangulating the results to uncover what was occurring on the unit at the time of the study. Furthermore, implementing a mixed methods approach to data collection and analysis afforded the study the opportunity to elicit the views of a variety of participants. Specifically, the views of those in charge of decision making (informants), the views of the front-line practitioners charged with the praxis of intermediate care and the views of consumers who have a firsthand account of the effectiveness of the service. All these play an important role in the delivery of intermediate care services and had different values or attitudes towards this level of care.

The design allowed the study to focus on the person-centredness aspect of the unit's model of care and to gain an understanding of how this unit embarked on or 'got behind' person-centredness and how this approach to intermediate care affected their care processes. Ultimately, this mixed methods case study design allowed the innovation journey that staff underwent to be uncovered and documented, thus, providing other practitioners and carers with a tangible example of what can happen when converting an ideological model of PCIC into practice.

7.4.2. Data collection and analysis

Early on in the development of intermediate care, Griffiths et al. (2001) noted that if intermediate care was to be fully understood researchers needed to assess not only the effectiveness of this level of care but the reason for its effectiveness. This recommendation resulted from the limitations of some early intermediate care research. By using a mixed methods approach, this case study was able to address this research need as identified by Griffiths et al. (2001) and supported by a gap in the literature, specifically, the paucity of research addressing both exploratory and confirmatory questions within a single study, particularly with regards to nursing home intermediate care (see chapter 2).

Using a mixed methods approach to investigating a contemporary phenomenon within its real-life context when multiple sources of evidence are used can generate a considerable amount of data (Gomm et al., 2000; Yin, 2003), as was the case in this study. Organizing and dealing with two data sets did not prove problematic, yet collecting the data was. As discussed in chapters 4 and 5, incomplete service users' records contributed to the study's incomplete data sets. These incomplete data sets were as a result of a) the staff's non-observance of the study's data collection requirements, specifically regarding the qualitative data and interviewing service users, (the staff's failure to contact me when service users were being admitted and discharged), and b) inconsistent recording of routine daily activities in service users' records. The former was eventually addressed by my going to the unit daily to see if any service users had been admitted or were waiting to be discharged. However, this amendment to the protocol was not made until November 2007, when it became evident that there was a problem with data collection and an amendment to the protocol could be agreed upon by all parties. In the latter, incomplete service users' records affected the quantitative data sets by having missing routine data (e.g. care package at admission, care package at discharge, estimated length of stay).

During the life of the study, the Unit Manager of JON decided that the unit would no longer follow up on the service users locations six weeks post discharge. For the service users who continued to receive care by social services once they returned home, the social workers were able to track their location six week post-discharge and provided me with this information. This was only for the service users who were still receiving social service care six weeks post-discharge from the unit. The remaining service users' location went unrecorded. It is crucial to be able to follow up on service users in order to address one of the gaps in our IC knowledge which focuses on long term effectiveness of the service.

Incomplete patient records were also included in the findings by Beech et al. (2004), who noted it was not possible to collect completed data for all relevant patients as patient case notes were of variable quality. Although incomplete data sets were initially a concern for this study, following further analysis, the missing data became part of the overall analysis. For example, the staff's inability/unwillingness to fully complete service users' records and engage in the research process was indicative of their functioning during the data collection phase. That being said, it must be noted that in many of the service user outcome variables the small sample size was further reduced due to missing data. This resulted in findings that are indicative of only a portion of the smaller than anticipated original sample size.

In addition to impeding quantitative data collection, the Unit Managers unilateral decision to stop recording six week follow up locations was an example of the autocratic leadership being implemented on the unit. Through the use of a mixed methods approach, this finding was able to be explored further during staff and informant interviews. Furthermore, thick description allowed the study to contextualize what else was happening on the unit at the time. This highlighted some of the factors contributing to the discrepancy between staff's enthusiasm for the study (and to have an account of their work in intermediate care) and their inability/unwillingness to record the data needed to do so.

During the data collection process, I was reminded of the term 'going native'. Although originally referring to ethnographers adopting the culture and behavioural characteristics of the population under study, I became cognizant that this can happen to anyone studying a phenomenon using a qualitative design. As Van de Ven et al. (1999) note some of the most 'gut wrenching' feelings can occur when undertaking an innovation. As a professional nurse, I sensed the pain and despair in some of the staff's expressions. However, I was aware of the need to remain neutral in collecting and analysing the data. My experience as an A & E nurse has afforded me many opportunities in which I had myself to use emotional labour to mask my feelings. At times, during the interviews, I wanted to console the interviewees and provide them with the praise and encouragement that they were longing for; however, I did not and I found this to be quite difficult. The positive quantitative data illustrated in the BSCs that were fed back to the staff intermittently did provide some of the positive reinforcement the staff were looking for. However, on a daily basis the vacant roles of mentor and sponsor affected the participants in this journey and this lack of support was evident in their interviews.

In order to ensure I was accurately interpreting these interviews, multiple interpreter control (see section 2.7.2.4.) was used to assist in validating the data by having early interviews and randomly selected subsequent interviews reviewed by one of my supervisors and fed back to me. This strategy was used to improve the analysis and consider the ideas and explanations generated by an additional researcher (my supervisor) studying the data (Johnson, 1997; Creswell & Miller, 2000). In retrospect, having this form of feedback from my supervisor provided me with confidence that what I was seeing emerging from the data was similar to what a second researcher saw. The qualitative themes generated from the staff and service users' interviews were presented to staff/informants as a means of formative feedback but also to ensure I was interpreting the findings in a way that was deemed truthful to the participants. As a novice researcher, I believe both of these activities were imperative to not only confirming my interpretation of the data but also ensuring I was not 'going native' and reflecting my own thoughts and ideas on what I wanted to be happening.

At the time of the study's development, in collaboration with informants, the study design was deemed to be suitable for collecting all the necessary data. By early December 2008, it was acknowledged by all parties (key informant, staff, supervisors and myself) that relying on staff to notify me of admissions and discharges was not as effective as originally anticipated and the data collection design was quickly amended to limit the amount of missed data. The change meant I was now going to the unit each day in order to track the movements of the current service user participants and be aware of potential admissions. Although the sample size did not reach the anticipated 118 service users, the change to the study's data collection protocol did significantly limit the potential impact and harm to data collection, which would have occurred had I continued on in the same vein. Therefore, on reflection, I believe that being on site every day from the onset of the data collection period would have afforded me the opportunity to be a) aware of all admissions and impending discharges, and b) in a position to complete the discharge interviews and satisfaction questionnaires without unduly charging the staff with the responsibility of notifying me of any admission/discharges.

7.4.3. The literature review

The purpose of this study's primary literature review was to acquire knowledge of intermediate care. Specifically, to uncover what was known about the service, from its development to current functioning units, how it had been researched and what the key issues were. Following data collection and analysis, a secondary review was completed. This focused on the research that had occurred during the life of the study. This was done to compare findings with other studies and acquire knowledge on this study's findings, such as emotional labour, group functioning and specific care outcomes, i.e. ELOS. The approach taken to conducting this study's literature review (primary and secondary post data collection and analysis) worked well.

From a constructivist point of view, I did not want to be unduly influenced by other intermediate care studies' findings as the data collection and analysis progressed. As stated in chapter 2, in order to ensure an unbiased approach to data analysis, following the development of the study's design, once data collection began, no further literature focusing on studies evaluating intermediate care were assessed until data analysis was complete. This approach to searching the literature, although common to many qualitative approaches, was yet another way to ensure the validity of this study's results. From a constructivist view, the interpretation of the data was not influenced by my perception of what was currently happening on other intermediate care units.

The body of literature surrounding intermediate care has been growing during the last part of this decade. Upon analysing the findings, a second literature search was conducted to assess what information had been published since the inception of this study and how my findings related to this research. The findings from this second literature search are interwoven throughout the later part of this thesis (chapter 6 and this chapter). In particular section 6.4 focuses specifically on how the findings from this study relate to the current body of PCIC literature. I believed at the time the study was designed and now, retrospectively, that remaining ignorant of current evaluative findings whilst data collection and analysis progressed, was in the best interest of the study. In conclusion from a retrospective consideration, this study's design and methods were chosen, as they worked to provide the best understanding of my research question. This research question was developed based on the funder's desire to assess the care being provided within their new establishment, the literature gaps in knowledge and my personal, professional and academic experiences.

7.5. How this study’s findings relate to other intermediate care research

The development and implementation of intermediate care has made considerable progress as the country has worked towards and achieved its national expansion targets (Young & Stevenson, 2006). The literature on intermediate care is growing. Over the last decade various studies have attempted to broaden the knowledge base by providing research on a variety of aspects of the service, such as from the perspective of, therapists and clinicians (Martin et al., 2004), the social and health care ‘joining- up’ policy (Moore, 2007), involvement of the voluntary sector (Manthorpe et al., 2006), cost effectiveness of the service (Walsh et al., 2005; Mayhew & Laurence, 2006), and patient satisfaction (Wilson et al., 2006). Some studies have focused on intermediate care being provided within NLUs (Steiner, 1997; Steiner et al., 2001; Wiles et al., 2001; Walsh et al., 2003; Griffiths et al., 2009), some from hospitals at home (Parker et al., 2009, Sheppard & Iliffe, 2005) and some from a combination of settings (Vaughan & Lathlean, 1999; Carpenter et al., 2002). However, the evidence base on intermediate care within a nursing home setting remains grossly under-represented. This is surprising as nursing homes are widely available facilities. Their ability to offer twenty-four hour supportive care, which is necessary for older people requiring intermediate care, makes them an ideal setting for this service. Moreover, the popularity of providing intermediate care in these settings has increased significantly within the UK (Wade et al., 2003; Griffiths et al., 2009; Young, 2009).

Intermediate care is a multifaceted service within the UK and as such requires a complex approach to its evaluation. The evaluation of an intermediate care model must accommodate the complexity of the intermediate care provision, covering the person receiving care, as well as the practitioners involved and the agencies responsible for providing that care (CAT, 2007). This study has confirmed the value of using a mixed methods approach within a single case study when faced with answering exploratory and confirmatory questions about intermediate care. Likewise, Beech et al. (2004) used a mixed methods descriptive design to assess intermediate care being provided by one local Rapid Response Team in home settings, and found the use of a mixed methods approach to be effective in addressing the complexity of intermediate care. As did Baker (2008) who attributed the use of a mixed methods approach to studying a particular intermediate care service, with addressing the multi-faceted nature of intermediate care, whilst making the study more robust. Similarly, mixed methods research has been applauded by other researchers for being able to accommodate the complexity of evaluating this service (Young et al., 2007; Moore et al., 2007; Martin et al., 2007; Regan et al., 2008). Furthermore, as can be seen from this study's findings, evaluating patient-centred outcomes alone fails to tell the whole story of intermediate care.

Akin to the JON Foundation, the Department of Health (Policy Research Programme) had a similar desire to gain a clear understanding of how intermediate care units/facilities were functioning nationally. Thus, in September 2001, the Department commissioned a £1.2 million evaluation and research programme (DH, 2002). The three major studies funded were: A National Evaluation of the Costs and Outcomes of Intermediate Care Services for Older People (Barton et al., 2006); An Evaluation of Intermediate Care for Older People (Godfrey et al., 2005); and A Multi-Centre Study of Effectiveness of Community Hospitals in Providing Intermediate Care for Older People (Young et al., 2007). The findings from these studies, as well as various follow up reports, have been woven throughout this study (Barton et al., 2006; Young et al., 2007; Regan et al., 2008). These nationally based studies have emphasised that there continues to be confusion in articulating various aspects of IC such as nationally accepted admission requirements; and fragmentation and poor integration with other services continues to impede IC's development (Moore & Keen, 2007; Green et al., 2005; Regan et al., 2008).

Within JON, the qualitative data from staff and informants' interviews highlighted the difficulty in implementing an ideological PCIC model under strict nursing home regulations. Additionally, staff were experiencing great difficulty in identifying what intermediate care was, what model of intermediate care was being used on the unit and how it differed from nursing home care and/or rehabilitation (see section 4.6.1.5.). Although, not unique to IC (McCormack, 2003; Nolan et al., 2004), these findings need to be investigated if practitioners are to understand and improve upon their IC practice.

It is hypothesized that the national confusion surrounding the practical implementation of intermediate care and the fragmentation that continues to exist in linking primary, community, secondary and social care provisions can account for some of the communication difficulties JON experienced internally (e.g. in identifying the theoretical model of care being used) and externally with outside agencies (Regan et al., 2008), specifically, the referring bodies' lack of knowledge surrounding JON's capabilities and eligibility criteria. Hebert and Lake (2004) noted in their work with twenty-five PCTs and their partners that it was those in charge of decision making in relation to referrals who had little detailed knowledge of what the intermediate care service could actually offer. Miscommunication of intermediate care's capability and eligibility could account for the lack of step up referrals to JON from the community.

The disproportionate representation of service users admitted as 'hospital admission avoidance', compared to the step down service users admitted from hospital as 'early discharge', was found at JON. At JON, the admission ratio was 20:80 in favour of step down; other studies noted a similar disproportion of set up admissions (Beech et al., 2004; Regan et al., 2008). Additionally, Regan et al., (2008) found that, within the communities they studied, there was a sense that the eligibility criteria for service users admitted into intermediate care from the community were too narrow. As a result, intermediate care services were at times seen as 'cherry picking' and being 'elitist'. Additionally, it has been suggested that poor involvement of, and communication with, local GPs has resulted in hesitancy in referring patients to intermediate care, thus further perpetuating the under-represented step up admissions within intermediate care facilities (Wilson & Parker, 2003).

One of the drivers for the development of intermediate care was to have the right service being delivered, to the right person, in the right place. It was anticipated that by doing so, acute hospital beds would be made available for acute patients and not be filled with medically stable patients requiring further rehabilitative care. In addition, patients who were medically stable, but unable to function in their current home environment, could avoid hospital admission by being admitted to a more appropriate facility that could provide them with the care they required. It is, therefore, concerning yet not surprising (due to the under-representation of step up admissions) that recent findings indicate, since the inception of intermediate care, acute hospital admissions have increased by 7.8% and hospitals continue to be hard pressed to free up beds (Young & Stevenson, 2006).

At JON there was an under-representation of service users being admitted from the community (thus avoiding hospital admissions). In addition, the stress from the local hospital(s)' need to free up beds was putting pressure on the unit to accept service users who were not suited for the service. Although frustrating to staff, the tension caused by the disparity between the hospital(s)' bed agenda and the need to provide the right service at the right place for an older person was not unique to JON. Whether it was the continued pressure on acute hospitals, or their (hospital) staff's lack of knowledge of intermediate care's capabilities, the fact remains that other studies also noted that communication with hospital-based referring bodies were equally as perplexing as the communication with community referring bodies that resulted in a lack of step up referrals (Regan et al., 2008).

Narratives from the staff interviews question the appropriateness of some referrals from the local acute care hospital(s). Staff suggested referrals were problematic due to service users being transferred to the unit who were *'not as we were told' (ID code 102).* In particular, it was noted some service users were transferred to the unit confused and/or unable to actively partake in rehabilitation. Furthermore, service users were transferred to the unit medically unstable and needed to be readmitted into hospital within days of transferring to the unit. Recent national guidance has been produced that stresses the need to refocus the provision of intermediate care on frail older people and not to exclude older people with mental health problems (DH, 2009). However, at the time of the study, JON's admission policy and a central tenant of person-centred care, was that all service users entering the facility needed to agree upon an estimated length of stay and treatment plan, which would not be possible in a state of confusion. Furthermore, 71.2% of service users required a longer period of care than the days estimated by the referrer and 28.8% stayed longer than the DH's guidance concerning intermediate care length of stay (between two and six weeks) (DH, 2001).

Although an increased LOS was noted in this study and other IC research studies (see section 6.4.), the process by which LOS is calculated differs between studies/organizations. For instance, some facilities/studies calculate LOS from the time of hospital admission, others from the time of admission to an intermediate care unit. Furthermore, as there was no control group with which to compare the sample of service users at JON that stayed longer than six weeks, there were too many uncontrolled variables to compare these findings to other increased LOS findings with any conviction. Therefore, the comparison of this study's LOS with other studies' findings was guarded and was only done to confirm that at JON 28.8% of service users stayed longer then the DH guidelines of two-six weeks as did other service users at other intermediate care facilities. More to the point, the reason for the increased LOS has yet to be confirmed through further research. As such it is only hypothesized that at JON some of these findings may have resulted from a lack of understanding/miscommunication on the part of referring agencies' regarding JON's function and capabilities and the inappropriate/premature admissions to the unit.

For the most part, the participants in this study improved (their functional ability) whilst receiving intermediate care at JON. Although similar findings were found regarding NLUs, Young (2009) argues that for those receiving intermediate care (on a nursing led unit) their increase in functional status could be a result of their increased length of stay rather than the intermediate care they received. When comparing these findings to those of NLUs it must be noted that there are extensive differences between the two. Griffiths et al. (2009) point out that although NLUs have provided the bulk of the research on IC, one must exercise caution when attempting to generalize evidence from this body of knowledge to intermediate care as a whole, as NLUs are complex and diverse. However, this is an area that would benefit from further study on a larger sample size and a control group on which to compare findings (see section 7.4.).

Fundamental to the NHS Plan (DH 2000b) was the development of a ‘whole system approach’, which would see health and social care agencies partnering to provide efficient care for patients. As noted in the findings, the working relationships between health and social service professionals on this unit had been long established. According to staff these relationships were initially problematic, but concerns and issues had been rectified prior to this study. This study’s findings do not lead me to propose that the integration of these two services can be done effortlessly, only that it was not an issue for this particular facility. In fact, JON’s positive collaborative practice between health and social care professionals separated them from other studies which found intermediate care units/facilities struggling to incorporate health and social care agencies into their multidisciplinary team (Moore et al., 2007). As such this study can also be seen as a unique contribution to the field of collaborative practice

Several of the findings, such as demographic and diagnostic characteristics, increased length of stay and under-representation of step up admissions, were similar to those observed in other intermediate care evaluations (Beech et al., 2004; Roe B 2003; Yohannes et al., 2008). However, it is important to note, due to the sample at JON, as well as other studies focusing on intermediate care, the findings are predominantly representative of caucasian English older people’s views and thus lack a multicultural perspective (Yahannes et al., 2008). Future research is needed to fill this gap. Further strengths and limitations of this study and recommendations for future research will now follow.

7.6. Recommendations for future research

The following section summarizes the recommendations for future research that have been put forward in this chapter.

- This study suggests that future research on multidisciplinary intermediate care teams should endeavour to include the medical perspective into the study's design. Some studies that have included the medical perspective found there was disengagement and lack of awareness of IC's capabilities and function on behalf of some GPs. Future research that incorporates the medical perspective could address this disconnect with GPs, while, concurrently assessing for possible relationships between this disengagement and the low step up admission rates found in this study and others (Wilson & Parker, 2003; Beech et al., 2004; Regan et al., 2008).
- A larger overall sample size which addresses how intermediate care is used by, and its effects on, other non-caucasian members of England's multicultural society is recommended.
- Research addressing the effect that working relations between private, public and voluntary sectors have on implementing intermediate care would be beneficial. Such research would be advantageous to future working relationships and to service users who are the beneficiaries of this care.
- It is suggested that further research questioning community and hospital referring bodies' understanding of intermediate care's capabilities and eligibilities and their referring practices should be undertaken.
- In order to address the need to comment on the long term effects of treatment, future studies should follow up on the location of service users post-discharge, their level of functioning and any changes to care packages.
- Finally, this study suggests that more research is needed to assess if intermediate care is successfully providing a continuum of care. Specifically, if it is linking primary, community, secondary and social care provision as it was meant to do (DH, 2000; DH, 2001) or if this aspect of IC is being ineffectively delivered as some studies suggest (Nancarrow, 2004; Regan et al., 2008).

7.7. Summary of the study

In England, decades of financial overspending and the resultant inherited economic pressures, coupled with a looming crisis of an ageing population, resulted in the NHS producing a ten-year plan to invest in and modernize the NHS (DH, 2000b). Intermediate care was a key element to this plan and focused on reducing public expenditure, relocating resources and providing an alternative to acute hospital admission for the ageing population. Intermediate care was endorsed as an important approach to promoting the independence of older people, whilst concurrently relieving pressure on the acute care sector. It was supported financially to the sum of £900 million by 2004 (DH, 2000b).

When intermediate care was first introduced into mainstream NHS, it was being implemented throughout the UK without the supporting research evidence needed to guide investment decisions. It lacked a theoretically based comprehensive model on which to replicate further practice and research. While within this specific study, the lack of a nationally accepted model of care on which to replicate practice was seen as one of the service's strengths. This allowed intermediate care to be applied to a wide range of circumstances and in this instance, to suit the varied needs of JON's community and individuals that it serviced.

The flexibility of the service provided JON the opportunity to be innovative by combining its own model of person-centred care with the pillars of intermediate care (e.g. six week time line, step up, step down admissions, et cetera). Similarly, in many parts of the country, locally led initiatives have been developed under the title of intermediate care, thus allowing them to address the need to promote faster recovery from illness, promote a more effective use of acute hospital beds, prevent unnecessary acute hospital admissions, support timely discharge and maximize independent living within their communities. The flexibility in the service model has also led to confusion and fragmentation. Specifically, within this study, it is hypothesised that this confusion has led to the under representation of step up admissions and the inappropriate/premature admissions of other service users on this intermediate care unit.

This study has endeavoured to fill a research gap in the intermediate care literature by providing a wealth of data that will enrich the current body of knowledge. This study's data are presented in the form of thick description which supports future research initiatives by detailing what worked and what didn't as one MDT underwent their innovation journey whilst delivering PCIC in a nursing home setting. Thus providing its readers with a detailed account of the unit's challenges and successes in order for other teams/researchers/individuals to replicate or to learn from JON's experience as they develop, implement and/or study their own form of PCIC.

This single descriptive case study investigated a contemporary phenomenon within its real-life context; it describes and examines the factors influencing the innovation journey of one nursing home intermediate care unit during its first two years of functioning. The organization at the core of the study was a not-for-profit, registered charity. This organization was dedicated to providing alternative configurations of services in order to improve the quality of life for older people as it strives to influence the future direction of healthcare for older people within the UK. Their latest venture was JON, a purpose built care facility which housed an intermediate care unit. Driven by a commitment to providing and enhancing quality care, and a belief that an innovative approach is vital to care, JON's model focuses on intermediate care delivered through the integration of the not-for-profit sector with health and social care service providers. This merger of three groups resulted in the formation of a multidisciplinary team working on this unit. The MDT consisted of three groups of carers and professionals employed by three separate employers (the JON Foundation, PCT and social services). The present study focused specifically on this group of carers and practitioners and the service users who were admitted into this 20-bed intermediate care unit.

Within this case study, a mixed methods design was implemented to capture the best of both qualitative and quantitative approaches. This design allowed the study to collect, analyse and discuss data from different data viewpoints in order to simultaneously answer the study's confirmatory and exploratory questions. The study utilised qualitative methods of in-depth data collection in order to generate thick description. This supported the study's aims and objectives. Specifically, explaining how a new event (e.g. intermediate care at JON) was understood and integrated into the culture of the facility. Data were gathered through: semi-structured interviews with twelve staff and four informants; semi-structured interviews with 94 service user participants; completion of 75 service users' Barthel index 100 scores (admission and discharge); 59 service users' satisfaction questionnaires; analysis of documents related to JON's development (e.g. minutes of meetings, annual reports) and analysis of routinely collected activity data that were held within JON. The qualitative data were analysed through thematic analysis. The findings generated through this analysis were reported to staff and informants as a means of formative feedback in order to share information, discuss progress and document reactions to the findings as they were presented.

Additionally, this study determined and commented on the impact and effectiveness of JON's initiative to meet its own predetermined success criteria in relation to: service user satisfaction; care outcomes; process; value for money; and cross-discipline/cross-agency communication and cooperation. The evaluation also exposed and commented on the critical factors that impacted positively and negatively, on the success of JON's intermediate care unit. Van de Ven et al.'s (1999) 'Innovation Journey' model was adapted for this study as an organizational framework in which to present JON's own innovation journey. This model supported an explanation of how the design and implementation of this new service at JON was often subject to a range of local and unforeseen influences. These influences resulted in setbacks which required the staff to use emotional labour in order to balance CSCI policy requirements and the needs of the unit to deliver person-centred intermediate care.

The innovation journey that the staff underwent as they developed and implemented a person-centred intermediate care model was diffuse, serendipitous and often fraught with changing personnel on the unit. This was further compounded by the need to adhere to nursing home regulations. Although personnel change can often lead to new opportunities for service realignment, such was not the case on this unit. As noted by Van de Ven et al. (1999) and experienced at JON, the fluid participation of those involved in this innovation was disruptive as staff and managers worked around filling posts. Of further concern was the lack of a mentor and a sponsor in order to provide support during this time of change and to counter the autocratic leadership that was dominating the unit.

Positive working relationships between individuals in the team were noted in the theme 'communication positively viewed at individual level' (see section 4.6.1.4(1)). These relationships, however, were being countered by other unhelpful professional relationships, as noted in the theme 'pulling care together despite: fragmentation within the MDT' (see section 4.6.1.2(3)). Disunity amongst the team meant the team needed to use a significant amount of emotional labour during their daily work life (see section 6.3) in order to enable PCIC to be successfully delivered on this unit.

The analysis of the quantitative data set indicated that very few participants came from the community (n=19). The majority (80%) of all the admissions were step down admissions from two local hospitals. Over half (56.3%) of all the participants were admitted with a diagnosis of falls and suffered (63.8%) from three or more pre-existing ailments. The ALOS ranged from 1-105 days with the majority (74.1%) of SUs being discharged to their own home. Over half (56%) of those discharged home required a higher level of support than that which they were admitted with. However, the majority (88%) of the service users who received care on this unit had a marked improvement in their level of functioning with a statistically significant mean change in functional ability of 24.3 (as measured by the BI 100). Unfortunately, for five participants, their level of independent functioning decreased whilst being cared for on the unit. Four service users did not have a change in BI scores; being admitted and discharged with scores of 66, 84, 85 and 85 respectively. One service user died whilst being cared for on the unit, and a further nine were transferred back to the hospital. Although these ten did not have a completed Barthel index 100 score, it is hypothesized that they had a decrease in their level of functioning. This leaves one to question the appropriateness of their being on an intermediate care unit in the first place.

From the quantitative data set, it could be concluded that the majority of the service users' needs were being successfully met by the MDT at JON's intermediate care unit as, on the whole, those admitted to the unit improved functionally and returned home. The service users' qualitative data set had similar findings and indicated that the majority of service users were satisfied with the care they received; the majority felt they became more independent and believed the team treated them with kindness, dignity and respect. Paradoxically, the staff's qualitative data indicated a dysfunctional team in jeopardy.

Fundamental to this study's findings was its use of a concurrent triangulated mixed methods design. Through this design, the study was able to triangulate the qualitative and quantitative data sets and expose the staff's use of emotional labour. A single methods case study would not have uncovered the true functioning of the unit. This study suggests that, through emotional labour, this dysfunctional team was able to successfully implement PCIC, resulting in, for the most part, the service users and their families believing the team at JON was a highly functioning team who communicated well and knew what each was doing.

By assessing both data sets separately then together, the study concludes that the majority of the service users were satisfied with the care they received. Additionally, for the most part, the quantitative outcomes were positive and supported the finding that the unit successfully implemented PCIC, albeit for a smaller than anticipated sample size. Some of the negative quantitative findings have been explained based on miscommunication/misunderstanding by outside agencies regarding the capabilities of the unit and of intermediate care's function as a whole. From the staff's qualitative data, it was concluded that at times due to miscommunication/misunderstanding of the service users' actual capabilities, the unit had accepted service users onto the unit who were not physically ready for intermediate care. These service users were either transferred back into hospital, declined significantly on the unit, stayed longer than their ELOS or in one case died on the unit.

When referring to discharge care packages, once again the use of a mixed methods approach to data collection allowed the study to expose the working of this unit. The quantitative data indicated over 56% of service users were discharged with a care package that was higher than the one they had prior to receiving care. From these data, one could conclude that JON's IC was not successful as service users needed more care at discharge than they did at admission. However, the service users' interviews illustrated that for some, a goal for them whilst at JON, was to sort out their care packages. In one case this was the underlying reason for admission. This explanation would have been missed by a single methods case study, o again confirming the strength of the design chosen

In closing, through the use of a concurrent triangulated mixed methods design this case study has provided the field of intermediate care with a detailed account of one intermediate care nursing home based person-centred care model. Specifically, the study provides a detailed account of how one team, in an attempt to meet the regulations of CSCI and the founding organization's own vision of person-centred care and be at the forefront of change in care of older people, underwent an exciting and challenging innovation journey whilst delivering intermediate care. This has provided the practice community with a detailed account of the successes and challenges that one MDT, made up of the voluntary sector, PCT and Social Services employees, experienced whilst crafting and successfully implementing their own unique model of person-centred intermediate care.

Older people are the main consumers of our health care. It is the responsibility of the professionals caring for them to ensure there is sufficient evidence on which to provide care that best meets their changing and complex needs. This study has added to this body of knowledge as a means of improving the care for all older people.

Appendix 1

LITERATURE SEARCH PROCESS

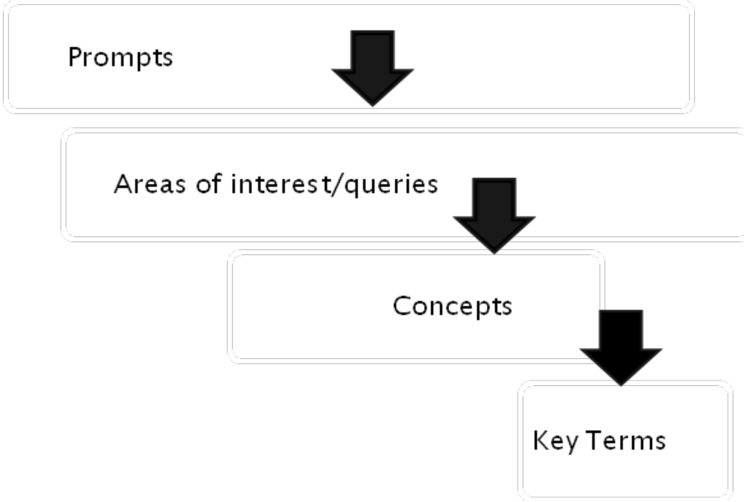
1.1 Primary literature review

The following are the primary prompts used to guide the primary literature review:

1. What is known about the global ageing population and what are the predicted issues that go along with it?
2. What is intermediate care, why was it introduced into the mainstream NHS and what is known about England's community based intermediate care service since its formal inception in 2001?
3. What is known about JON and its newly developed intermediate care unit?
4. What does an intermediate care model look like, what is known about the collaborative practice relationships that need to exist within such a model and has the effectiveness of such a model been studied? If so, what tools exist to measure care outcomes and satisfaction with care?

Figure 2.1 illustrates the flow in which the above-mentioned prompts gave rise to specific areas of interest, and queries which were refined into key concepts, which were concentrated into the key terms used to refine the search.

Figure Appendix 1.1 The concentration of search terms



The areas of interest and queries are summarised in Table 1.1.

Table Appendix 1.1 Areas of interest and queries

Prompts	Areas of Interest	Queries
1	Ageing Population	Current and predicted numbers Health care issues
2 & 4	Intermediate Care	History Who has studied it? Criteria for it and who decides these criteria?
3 & 4	JON	History Why was JON developed and who is part of their MDT? What evaluation tools are currently being used on site?
2 & 4	Health Care Models	What community based IC models exist? What nursing home IC models exist? What person-centred IC models exist? Are the models nationally accepted and have they been evaluated?
4	Care Outcomes	Can an increase in independence in older people be measured? What tools exist? What are the pros and cons of each tool? Do intermediate care measurement tools exist? What are the pros and cons of each?
4	Satisfaction with Care	Can you measure patients' satisfaction with care? What tools exist to do so? What are the pros and cons of these tools? What are the pros and cons of measuring satisfaction with care in the older population?
4	Collaborative Practice	What is known about bringing different teams (health, social) together within an IC setting? How does a MDT develop an IC model?

The aforementioned areas of interest and questions were further reduced to the following concepts:

1. Ageing population/older people
2. Intermediate care

3. Community/ nursing home care

4. Service evaluation

5. Collaborative practice within intermediate care.

Under the umbrella of these central concepts, the following key terms refined the search and increased the relevance of the information retrieved.

Key terms:

- Ageing Population
- Older people
- Intermediate care
- Community care/nursing home care
- Service evaluation
- Collaborative practice
- Rehabilitation

All key terms were used to create a defined, consistent and iterative search plan and were entered into the following search indexes and databases:

- CINAHL
- Unicorn (Kings Fund)
- Medline
- National Library (National Electronic Library for Health-NHS- National Health Services)
- British Library-EThOS-Beta-Electronic thesis online services
- DH
- The Cochrane database
- NHS Centre for Reviews and Dissemination
- Grey Literature (EAGLE)

This structured search was further extended by using the thesaurus on each of the above mentioned databases and indexes, in order to identify and search these terms under relevant synonyms and by use of appropriate truncations. The expanded terms are located in Table 1.2.

Table Appendix 1.2 Expanded search terms

Key Terms	Expanded Search Terms
Ageing Population/ Older People	• Elderly/Old • Aged/Mature • Adult
Intermediate Care	• Transitional • Rehabilitation • Community care • Secondary care • Nursing home • Functional assessment • Effectiveness • Patient outcomes • Research • Evaluation
Community Care	• Neighbourhood • Hospital at home • Nursing home • Independently owned • Non-hospital
Service Evaluation	• Assessment • Appraisal • Measurement • Valuation/Review • Survey
Collaborative Practice	• Joint/ Combined • Multi-party • Cooperative • Shared

The initial search was conducted between October 2006 and March 2007 inclusively. A second review took place between September and December 2008. The third and final review took place between January and October 2010 (see section 1.2). The timeframe for the initial search was 2000-2006. However, it was established that intermediate care was functioning prior to its formal inception in 2001 and therefore the search was widened to include all literature published during the timeframe 1990-2007. As no pertinent evidence was found dating before 1996, the second and the third searches were further refined to 1996-2008 inclusively. The final search incorporated the findings of the data between 2000- 2010, plus seminal work. All searches were open to both quantitative and qualitative studies, books, policies, gray literature (e.g. doctoral thesis, conference papers), theoretical papers, commentaries, and systematic reviews. However, in keeping with the rationale for this background literature review, search boundaries were set and organised. These boundaries and the rationales for them can be found in Table 1.3.

Table Appendix 1.3 Search limits and rationale

Search Limit	Rationale
Language - English speaking facilities	I can only read and speak fluently in English and the study does not have the resources required to employ an interpreter.
Subject area - Any facility offering IC services	JON is an IC facility. Although JON is a nursing home intermediate care facility all intermediate care literature was included in order to gain a general understanding of this new level of care.
Region for ageing population trends - Worldwide	Gain understanding of worldwide concern with ageing
Region of intermediate care - England	JON is located in England.
Sample - People aged 55+ - Service users must have the mental capacity to give informed consent	Service users being admitted to JON's intermediate care unit must be 55+ and able to give informed consent.
Age of papers/documents	- 1996- present day + seminal work

1.2. Secondary Literature Review

The process used to review the literature for the secondary literature search was heuristic and iterative and complete, when no new records or retrievals of information occurred. A focused and consistent approach was employed during this process and the following are the primary prompts used to guide this review:

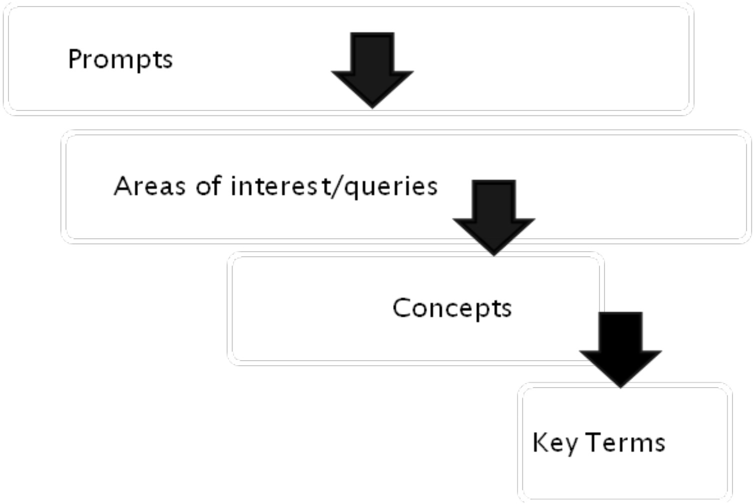
1. What is known about person-centred intermediate care?

2. What is known about emotional labour? Has it ever been associated with intermediate care?

3. What is known about normal team functioning?

Figure 1.2. illustrates the flow in which the above-mentioned prompts gave rise to specific areas of interest, and queries which were refined into key concepts, which were concentrated into the key terms used to refine the search.

Figure Appendix 1.2 The concentration of search terms



The areas of interest and queries are summarised in Table 1.4.

Table Appendix 1.4 Areas of interest and queries

Prompts	Areas of Interest	Queries
1	PCIC	What is known about PCIC within a nursing home setting and what are the driving factors and restraining forces to implementing this model of care within this sector?
2 & 4	Emotional labour	What is it? How does it affect care? Has it been associated with providing intermediate care? Has it been associated with providing person-centred care? Has it been associated with team development? Has it been associated with developing and implementing new services/care models/
3 & 4	Team functioning	What is known about normal team functioning?

The aforementioned areas of interest and queries were further reduced to the following concepts:

1. Person-centred
2. Intermediate care
3. Nursing home intermediate care
4. Person-centred intermediate care
5. Emotional labour
6. Group functioning

Under the umbrella of these central concepts, the following key terms refined the search and increased the relevance of the information retrieved.

Key terms:

- Emotional labour
- Person-centred intermediate care
- Nursing home intermediate care
- Group functioning

These key terms were used to create a defined, consistent and iterative search plan and were entered into the following search indexes and databases:

- CINAHL
- Unicorn (Kings Fund)
- Medline
- National Library (National Electronic Library for Health-NHS- National Health Services)
- Brtish Library-EThOS-Beta-Electronic thesis online services
- DH
- The Cochrane database
- NHS Centre for Reviews and Dissemination
- Grey Literature (EAGLE)

This structured search was further extended by using the thesaurus on each of the above mentioned databases and indexes, in order to identify and search these terms under relevant synonyms and by use of appropriate truncations. The expanded terms are located in Table 1.5.

Table Appendix 1.5. Expanded search terms

Key Terms	Expanded Search Terms
Person-centred intermediate care	• Person centredness • Patient- focused care • Patient-centred work • Patient-centred care • Client centred practice • Client-centred care • Client focused care • Person-centred approach • Patient-centred intermediate care
Nursing home intermediate care	• Community based nursing home care • Residential home intermediate care
Emotional labour	• Emotions • Emotional intelligence • Sentimental work
Group Functioning	• Team functioning • Team work • Management styles

The secondary search incorporated the findings of this study and the time frame searched was between 2000– 2010, plus seminal work. The search was open to both quantitative and qualitative studies, books, policies, gray literature (e.g. doctoral thesis, conference papers), theoretical papers, commentaries, and systematic reviews. The search boundaries set for this secondary literature review and the rationales for them can be found in Table 1.3.

Table Appendix 1.6 Search limits and rationale

Search Limit	Rationale
Language	I can only read and speak fluently in English

- English	and the study does not have the resources required to employ an interpreter.
Region of person-centred intermediate care - England	JON is located in England.
Age of papers/documents	- 2000– present day + seminal work

1.3. Critiquing of the primary and secondary literature search findings

The European Association for Gray Literature Exploitation (EAGLE) was used to search for pertinent gray literature. At the time of the above-stated literature search, there was no gray literature on person-centred intermediate care.

An amalgamation of critiquing guidelines, developed by the Critical Appraisal Skills Programme (Crombie 1996, Ryan, Coughlan & Cronin 2007) were used to evaluate the rigour of each research paper, and to review the literature presented in this thesis. From this literature search, a total of 209 reports, documents and papers were identified. All 209 reports, documents and papers were reviewed in accordance to the above mentioned critiquing guidelines, and those found to be pertinent to this study are referenced throughout the body of the thesis (see Figure 2.2).

The overall considerations that were taken into account when evaluating the believability of each research paper presented in this thesis were:

- Report title – Is it clear, precise and unambiguous?
- Writing style – Is the report well written? Is it well structured and organised?
- Author(s) – Does the researcher(s)' qualifications/ position indicate a degree of knowledge in this field?
- Abstract – Does it include the research problem, sample, methodology, findings and recommendations?

The specific elements that were assessed as a means of evaluating the robustness of each research paper were:

- Defining the purpose or significance of the study – Is the aim of the research clearly laid out? Is the nature of the research question(s) appropriate?
- Literature review – Does the literature review offer a balanced critical analysis of the literature? Is there a clear match between the research aim/ question(s) and the literature review? Does the question(s) reflect the information presented in the review? Is the majority of the literature of recent origins?
- Methodology – Is the research design clearly identified? Is the chosen methodology appropriate to address the aim/question(s) of the study?
- Sampling – Has the target population been clearly identified? Is there an appropriate match between the research aim/question(s) and the sampling strategy? Was the sampling method and size disclosed? Are the inclusion/ exclusion criteria clearly stated? Were the participants fully informed about the nature of the study?
- Data collection/data analysis – Has the data collection strategies been clearly identified? Is there evidence of systematic data collection? Are the data collection methods clearly appropriate for the given study and its aim/ question(s)? Are the strategies used to analyse the data described and are they appropriate to the aims/question(s)? Does the data collection and data analysis process follow a logical manner?
- Findings and discussions – Were the findings and their implications clearly presented and with a clear distinction between the two? Are the findings linked back to the literature review? If a hypothesis was identified, was it supported? What is the significance of the findings? Where the strengths and weaknesses of the study discussed? Are the findings relevant to the body of knowledge and theory that exists already? Are the findings relevant to current academic audiences, practitioners, management and policy makers in the field?
- Overall rigour to the analytical process – How was rigour assured? Are all the terms, theories and concepts clearly defined? Were credibility, dependability, goodness and transferable/ generalizable discussed?
- Conclusion/ recommendations –Were the limitations of the study discussed and was there any recommendation for further research?
- References – were all sources included in the study clearly referenced?

Appendix 2

FORMATIVE FEEDBACK

Formative feedback was incorporated into this study as a means of keeping the staff abreast of the emerging themes from their interviews. In addition, it provided them with 'snapshots' (BSCs) of how the unit was functioning in regards to the quantitative data collected in order to provide them with an opportunity to reshape their care if need be. The following is an example of how the formative feedback process worked with the staff.

All staff interviews were analysed and collated to form themes. During the subsequent set of interviews (February/March 2008 and June/July 2008), the themes from the previous set of interviews and the respective BSC were presented during the interview session to the individual staff participant who was then asked to assess and comment on these documents. This form of formative feedback functioned to a) clarify with the staff the themes generated from the preceding interviews (ensuring validity of the findings) whilst commenting on the balanced score card produced; and b) generate new findings, which then underwent analysis to build categories and develop themes based on how the service was functioning during that particular time frame. For example, the quantitative data collected from September 2007- January 2008 produced balance score card # 1 (see Appendix 6) which indicated that, during the first six months of the study, 95% of service users believed the service adapted to meet their needs and preferences. Following the distribution of this BSC and the list of themes (see Figure 4.4) each participant was asked to comment on the documents. The staff unanimously agreed with the themes presented. The first part of the interviews was dominated with comments such as:

It makes me feel relieved to see these ...I wasn`t the only one...justification really.

Identification code 112,103 & 101

Staff comments regarding the BSC were primarily focused on expressing pride in having such high percentages of service users commenting on their improvement and being treated with kindness, dignity and respect. One comment of particular interest regarding the BSC was from a staff member who said:

Amazing really. We are falling down around them but they still think we're great.

Identification code 111

The comments shared by staff in response to the themes and the BSC were considered part of the overall interview process and underwent the same rigorous analysis described in section 3.8.1.

During the second set of interviews, staff were asked to comment on the results of this balance score card and asked to comment on how the unit had been functioning since the last set of interviews. The feedback received during these sessions assisted in generating the qualitative data that ultimately facilitated in answering the research question (see section 2.4).

Although the goal of implementing formative feedback during this study was to assist in refining care, according to staff interviews, participants did not integrate these findings into their daily practice. Rather, they stayed entrenched in their current model of practicing and were looking outwards for someone else to make a change. The staff's inability to use the formative feedback as guidance on which to improve practice is not uncommon during an innovation journey. Their search for a 'hero leader' (see section 4.6.1.5.(3)) impeded their ability to grow. They were unable to assess this feedback and integrate it into their care as a means of ensuring they were evolving in a manner which was in the best interest to the team and to the service users they were providing care for.

On July 31 2008, a group meeting was held at JON for all staff who had dedicated working hours on the unit. The notices for the meeting identified the meeting as an opportunity to discuss 'where we came from and where we need to go'. At the Unit Manager's request, I presented the final set of staff themes during this meeting. Following my presentation, the Unit Manger asked the staff if they felt the study's formative feedback, given over the last year, was useful to the staff's practice. The following is an amalgamation of the remarks made in this session:

It was useful…very perceptive…justification…helped to identify problems.

I then asked those present ‘What have you done with the formative feedback?’

The following remarks were made:

I don’t think we really did anything with it, just sort of gave us confidence that we were being taken seriously…it did place ownership and told us how the team was working and the unit was getting on…it was helpful but I can’t say it has led to any real or lasting changes.

During the meeting various areas of concern (all of which have been addressed in chapter 4) were articulated by a few of the staff present. The meeting concluded with the Unit Manager suggesting a further informal meeting with the staff to be scheduled to ‘follow up’ on these concerns. A suggested date in December was put forward, which was nearly six months away.

Appendix 3

STAFF AND INFORMANT INFORMATION SHEET

An evaluation of intermediate care in the community

N.B. Large print versions of this information sheet and consent form are available on request.

Researchers: Heather Fillmore Elbourne, Dr. Andrée le May,

Dr. Bronagh Walsh.

You are being invited to help us with a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

My name is Heather Fillmore Elbourne and I am a registered nurse who is conducting a research study as part of my post graduate studies at the University of Southampton within the School of Nursing and Midwifery. Dr. Andrée le May and Dr. Bronagh Walsh are my supervisors.

In this study we aim to describe the work of [ ] community based intermediate care centre during its first two years of functioning and to evaluate the effectiveness of this model of care for service users and practitioners.

Why have I been chosen?

You have been chosen as one of the staff/ informants who have dedicated working hours at the intermediate care unit with direct service user contact and /or direct managerial functioning with the centre.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your employment at

[ ]. If you would like to participate you will be asked to complete the consent form and place it in the envelope provided to you. You can change your mind about taking part at any time. If you do withdraw once the study has begun you will be given the option of allowing the researchers to use the information collected from you up until your withdraw or remove all information concerning you from the study.

What will happen if I take part?

If you decide to take part in the study:

- You will be asked to complete a reply slip; this will contain your preferred contact details, and send this slip to the researcher in a self addressed envelope.
- A researcher will contact you with the date for the initial interview.
- In order to ensure privacy, interviews will be conducted in a dedicated private interview room. You have the option of being interviewed in a private interview room:
    1. On the unit

    2. Off the unit, but still within the [ ] complex, or

    3. At the University of Southampton, School of Nursing and Midwifery Highfield campus.

You will be asked to indicate your preference for an interview location on your reply slip. At anytime during the study you have the option of changing the interview location should you wish. If the interviews take place at the facility they will be held before, during or immediately after a work shift; therefore no additional travel on your part will be necessary. If you choose to be interviewed at the University of Southampton a time convenient to you will be scheduled.

- There will be a total of three interview sessions one occurring approximately every four months over a twelve month period.
- All interviews will be audio-taped.
- The first interview session will take place within one month of you agreeing to take part in the study and during this initial interview you will be asked to sign a formal consent form.
- The interviews will last for up to one and a half hours and will be divided into four parts:

1. The researcher will ask if you are happy for her to turn on the digital recorder.

2. The researcher will provide feedback on the data collected since the last interview.

   - Each interview will begin with the researcher providing formative feedback from the last set of interviews and a model representation using a balance score card.
   - All participating staff and informants will receive the same feedback information at their individual interview sessions.
   - The data presented to all participating staff and informants during these interviews will be made anonymous in such a way that all identifying features (e.g. name, title, professional grade, and professional group) will be removed from the data and all participants will receive an identification code.
   - No material easily leading to identification (e.g. name, professional designation or the coding system) will be kept with the data or used in the data analysis or during these feedback sessions.
   - Given the case study nature of this research there will be times that you may recognise yourself in the data (such as during these feedback session). However, the data will be made anonymous in such a way (removing all names, professional grades, professional designations and providing all participants with a code) that others will not be able to identify you.

3. The researcher will invite you to comment on this analysis.

4. The researcher will ask questions from the interview guide. The interview questions are designed to learn more about how differing groups of professionals come together to develop and implement a model of care. For example, the participant's perception on what is (or not) currently working in the delivery of the service.

- Once a year, over the next 3 years, a group information session for staff/ informants will be held to discuss the progress and findings of the study.
  - The data presented during these feedback sessions will be made anonymous in such a way that all identifying features (e.g. name, title, professional grade, and professional group) will be removed from the data and all participants will receive an identification code.
  - No material easily leading to identification (e.g. name, professional designation or the coding system) will be kept with the data or used in the data analysis or during these feedback sessions.
  - Given the case study nature of this research there will be times that you may recognise yourself in the data (such as during these annual group feedback sessions). However, the data will be made anonymous in such a way (removing all names, professional grades, professional designations and providing all participants with a code) that others will not be able to identify you.
  - These information sessions will take place at [ ].

What do I have to do?

As a participant in this study you will be asked to complete and return the reply slip to the researcher and attend all scheduled interview sessions. It is expected that during the interview sessions you share your views/ideas and opinions openly and freely with the researcher conducting the interview.

What are the possible disadvantages and risks of taking part?

Taking part in this study will not affect your employment at

[ ] in any way now or in the future.

What are the possible benefits of taking part?

There are not direct benefits from being involved in this research because it does not affect your employment at [ ]. However, your participation will allow us to better understand the needs of practitioners, like you, when they are developing and implementing new models of intermediate care. It is the intention of this research to assist in planning and improving the care and experience of service users and the working environment for practitioners, like you, who are developing and delivering a new model of care in the future.

What if there is a problem?

Complaints

If you have any concerns about any aspects of this study, you should ask to speak with the researchers who will do their best to answer your questions (see section on contact numbers). If you remain unhappy and wish to complain formally, you can do this through [ ] directly. Details can be obtained from the centre. Alternatively you can contact the Research Administrator at the School of Nursing and Midwifery, University of Southampton- Tel; 023 8059 7942.

What will happen if I become upset or distressed during the interviews?

Should you become upset or distressed in any way during the interviews; the researcher will ask you if you would like to stop the interview. You will have the option of being referred to the Unit Nurse Manger to discuss your concerns if you would like and the interview can be rescheduled at a later date if you wish to do so.

In the event the researchers witness hearing unsafe practice this information will be passed on to the Unit Manager at [ ].

Will my taking part in this study be kept confidential?

All information collected about you during the course of the research will be kept strictly confidential and secured against unauthorized access.

- No data will be presented alongside any demographic or descriptive information.
- All identifying features (e.g. name, title, professional grade, and professional group) will be removed from the data and all participants will receive an identification code.
- No material easily leading to identification (e.g. name, professional designation, coding system) will be kept with the data or used in the data analysis or during the feedback sessions.
- Given the case study nature of this research there will be times that you may recognise yourself in the data. However, the data will be anonymised in such a way (removing all names, professional grades and professional designations) that others will not be able to identify you.
- The data collected will be used for this study alone.
- The procedure for handling, processing, storage and destruction of the data are compliant with the Data Protection Act 1998.
- Audio-recordings and written notes from you will be retained for 15 years in accordance with the University of Southampton's regulations and then destroyed.
- In view of this we will need your consent to these arrangements. You will be asked to sign consent form agreeing to participate in this study and for the material to be used for research purposes.
- You have the right to check the accuracy of data held about you and correct errors.

Who is organizing and funding the research?

The faculty of Medicine, Health and Life Sciences at the University of Southampton is funding this study.

Who has reviewed the study?

The study has received scientific scrutiny from researchers at the University of Southampton, School of Nursing and Midwifery. In order to protect your safety, rights, wellbeing and dignity, all research in the School of Nursing and Midwifery is looked at by a group of people, called the School Ethics Committee. This study has been reviewed by the committee and given favourable opinion.

Contact Details

This information sheet is yours to keep. If you decide to take part in the study you will also be given a copy of your signed consent form. If you should require any further information about this research, please do not hesitate to contact|:

Heather Fillmore Elbourne

Tel: 01489 573 432

OR

Dr. Andrée le May

Tel: 02380 8059 7968

Thank you for taking the time to read this information sheet.

If you are willing to take part in this study, please sign the consent form, place it in the envelope provided and post it within the next 7 days.

Appendix 4

STAFF AND INFORMANT REPLY SLIP

I _________________________ agree to take part in the study titled: An evaluation of intermediate care in the community.

I can be contacted at:

Telephone :(home) ______________

(Mobile)_____________

E-mail ________________________

My preferred times to be contact are ______________________________

Signature_______________________ Date ___________________

Appendix 5

SERVICE USER INFORMATION SHEET

An evaluation of intermediate care in the community

N.B. Large print versions of this information sheet and consent form are available on request.

Researchers: Heather Fillmore Elbourne, Professor Andrée le May,

Dr. Bronagh Walsh.

You are being invited to help us with a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve.

- Please take time to read the following information carefully and discuss it with others if you wish.

- Please ask us if there is anything that is not clear or if you would like more information.

- Take time to decide whether or not you wish to take part.

What is the purpose of the study?

- In this study we aim to describe the work of [ ] which is a facility located in the community that is providing care to people.

- We are interested in looking at this facility during its first two years of functioning and to evaluate the effectiveness of the care they are providing.

Why have I been chosen?

- To evaluate the effectiveness of the care at [ ] we will be looking to recruit a sample of

  people between September 2007– August 2008.

- You have been chosen to participate in the study because you have been admitted into the centre during this time and you are requiring intermediate care.

Do I have to take part?

- No. It is up to you to decide whether or not to take part in this study and you can change your mind about taking part at any time.

- If you wish to be part of the study you will be given this information sheet to keep and we will ask you to sign a consent form.

- At anytime if you no longer want to be part of the study you are free to drop out of the study and you do not need to give us a reason why.

- A decision to drop out of the study at any time, or a decision not to take part in the study, will not affect the care you will be given at [ ].

- If you would like to be involved in our study a researcher will come to your room tomorrow and talk with you about the study and answer any questions you may have.

- If you drop out of the study once the study is underway you can ask the researchers to remove all information about you from the study or you can let the researchers use all the information collected from you up until you dropped out.

What will happen if I take part?

1. If you decide to take part in the study, a researcher will arrange a time for an interview. This will normally be as close to your admission to the centre as possible and at a time convenient to you. In order to ensure privacy this interview will normally be carried out at the bedside in your room.

The interview will last up to 10 minutes. During this time the researcher will:

- Answer any questions you may have about the study and have you sign a formal consent form.

- Ask you about your expectations of the care you will receive during your stay at the centre. The researcher will record your answer on paper.

Once you are ready for discharge the researcher will come to your room for the final interview, this will last for up to 10 minutes and during this time the researcher will:

- Remind you of the answers you gave during the first interview regarding your expectations of the centre. The researcher will then discuss with you if the care you received during your stay met with your initial expectations. The researcher will record your answers on paper.

- Give you a satisfaction questionnaire that will ask you questions about the care you received at the centre. You can complete this questionnaire at home and you will be given a self addressed envelope that you can put the completed questionnaire in and post it within 7 days of your discharge. We will ask you to take a moment and read over the questionnaire and we will answer any questions you may have about completing and returning this questionnaire. We will ask you to provide a preferred contact number in which the researchers can contact you within 2 weeks of discharge if the questionnaire has not been returned in order to ensure no difficulties arose during its completion. The contact

- information you provide will be recorded and safely stored following the University of Southampton's guidelines for data storage. Once the questionnaire has been returned to the researcher or following the 2 week reminder phone call this contact information will be destroyed following the University of Southampton's guidelines for data destruction.

2. We are very interested in how you improved during your stay at [ ]

- With the assistance of the Unit Nurse Manager we would like to create a rehabilitation profile of your independence using a measurement scale.

- We would like to assess your score upon admission and then again at discharge. You will not need to be present for this.

- This information can come from the Unit Nurse Manager who will be familiar with your abilities.

3. We are very interested in your progress once you leave the centre.

- Therefore, 6 weeks after your discharge the researchers would like to look at [ ] files to see if you have been readmitted into the hospital or have been admitted into another care facility and why you were admitted.

- We will not need to contact you for this.

What do I have to do?

If you do decide to take part in this study:

- A researcher will arrange to meet and conduct the first interview. This will include signing a formal consent form and answering the question explained earlier in the service user information sheet.

- You will then see the researcher again once you are ready for discharge. This will include answering the question explained earlier in the service user information sheet and being given the questionnaire and self addressed envelope also referred to earlier in the service user information sheet.

- You will be asked to complete this questionnaire and return it by post within 7 days of your discharge.

- You will not see the researcher again. We will have a look at your medical notes in order to follow up on your destination but you will not need to be involved with this.

What are the possible disadvantages and risks of taking part?

Taking part in this study will not affect your care or treatment in any way now or in the future.

What are the possible benefits of taking part?

There are no direct benefits to you personally from being involved in this research. However, you participation will allow us to better understand the needs of service users, like you, when they are admitted into [ ]'s intermediate care unit. It is the intention of this research to assist in planning and improving the care and experience of service users, like you, who are receiving intermediate care in the future.

What if there is a problem?

Complaints

If you have any concerns about any aspects of this study, you should ask to speak with the researchers who will do their best to answer your questions (see section on contact numbers). If you remain unhappy and wish to complain formally, you can do this through [ ] directly. Details can be obtained from the centre. Alternatively you can contact the Research Administrator at the School of Nursing and Midwifery, University of Southampton- Tel; 023 8059 7942.

What if I should become upset or distressed during the interviews?

At any time during your participation should you become upset or distressed in anyway the researcher will stop the interview and will refer you to the nurse caring for you. You will be given the option to reschedule the interview at a later if date if you wish to do so.

Will my taking part in this study be kept confidential?

All information collected about you during the course of the research will be kept strictly confidential and secured against unauthorized access.

- Identification codes will be assigned to all forms of data collected to protect your anonymity and any identifying material removed.

- The data collected will be used for this study alone.

- The procedure for handling, processing, storage and destruction of the data are compliant with the Data Protection Act 1998.

- Audio-recordings and written notes from you will be retained for 15 years in accordance with the University of Southampton’s regulations and then destroyed.

- In view of this we will need your consent to these arrangements.

- You will be asked to sign consent form agreeing to participate in this study and for the material to be used for research purposes.

- You have the right to check the accuracy of data held about you and correct errors.

What will happen when I am discharged from [   ]?

Once you leave the facility you will not see the researchers again. However, it is important for us to follow up with the care you received as a service user at [   ]. [ ] is routinely informed if previous services users are readmitted into the hospital or admitted into a care facility following their discharge from the centre. Therefore, 6 weeks after your discharge the researchers would like to look at [ ] files to see if you have been readmitted into the hospital or have been admitted into another care facility and why you were admitted.

Who is organizing and funding the research?

The faculty of Medicine, Health and Life Sciences at the University of Southampton is funding this study.

Who has reviewed the study?

The study has received scientific scrutiny from researchers at the University of Southampton, School of Nursing and Midwifery. In order to protect your safety, rights, wellbeing and dignity, all research in the School of Nursing and Midwifery is looked at by a group of people, called the School Ethics Committee. This study has been reviewed by the committee and given favourable opinion.

Contact Details

This information sheet is yours to keep. If you decide to take part in the study you will also be given a copy of your signed consent form. If you should require any further information about this research, please do not hesitate to contact:

Heather Fillmore Elbourne

Tel: 01489 573 432

OR

Dr. Andrée le May

Tel: 02380 8059 7968

Thank you for taking the time to read this information sheet.

If you are willing to take part in this study, please notify the Unit Nurse Manger. She will contact a researcher, who will come to the centre tomorrow, answer any questions you may have about the study and have you sign a consent form.

Appendix 6

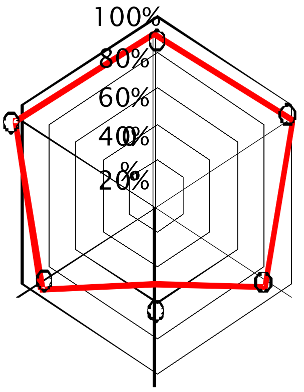
BALANCED SCORECARD

September 2007-

January 2008

IS OUR PERFORMANCE BALANCED?

VALUE FOR MONEY The service received adapted to meet my needs and preferences-95% agreed/strongly agreed



CARE OUTCOME The service helped me be more independent-98% agreed/ strongly agreed

USER SATISFACTION-The team treated me with kindness, dignity and respect-98% agreed/strongly agreed

CARE OUTCOME 79 % of service users had a +'ve increase on their Barthel index score

USER SATISFACTION The team communicated well and knew what each other were doing-78% agreed/strongly agreed

PROCESS 37 % of service users had a LOS that was ≤ to their ELOS-

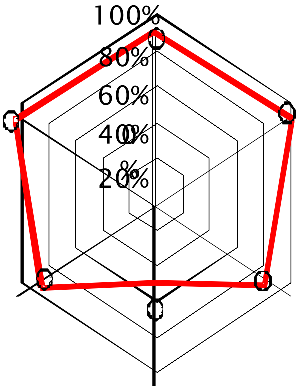
Appendix 7

BALANCED SCORECARD

February – June 2008

IS OUR PERFORMANCE BALANCED?

VALUE FOR MONEY The service received adapted to meet my needs and preferences-95% agreed/strongly agreed



CARE OUTCOME The service helped me be more independent-98% agreed/ strongly agreed

USER SATISFACTION-The team treated me with kindness, dignity and respect-98% agreed/strongly agreed

CARE OUTCOME 79 % of service users had a +'ve increase on their Barthel index score

USER SATISFACTION The team communicated well and knew what each other were doing-78% agreed/strongly agreed

PROCESS 37 % of service users had a LOS that was ≤ to their ELOS-

Appendix 8

STAFF INTERVIEW GUIDE

The following questions will be used to guide the staff and informant interviews:

To be asked during the initial and the final set of interviews:

- What is intermediate care?

- What is the purpose of JON's intermediate care unit?

To be asked during all interviews:

- What are the characteristics of the service users currently being admitted to the centre?

- What would the characteristics of an 'ideal' service user be?

- Staff working at the intermediate care unit is made up of a mixture of health and social service care providers who came from other facilities prior to joining the JON team. In regards to the centre's current multidisciplinary approach to development and implementation of an intermediate care model:

    - What is working?

    - What can be improved upon?

Appendix 9

SERVICE USER INTERVIEW GUIDE

Identification #

Service User Interview Guide – Initial Interview

Please help us by answering the following questions. Your feedback will help us identify ways to improve our service.

1. Please tell us in your own words what you think this service will offer you. (For example: During your rehabilitation here on the unit which aspects will be most useful to you?)

Service User Interview Guide – Discharge Interview

Please help us by answering the following question. Your feedback will help us identify ways to improve our service.

2. During your first interview you said 'quote first interview answer'. Please explain for us in your own words if and how (or not) the service met this specific aspect of your care?

Appendix 10

SERVICE USER SATISFACTION QUESTIONNAIRE

Intermediate care

Service user questionnaire

Thank you for agreeing to take part in this review of intermediate care services.

The findings of this survey will help us to know what people like you think of the service and how it can be improved. Your answers are of course strictly confidential.

Thank you..

Appendix 11

THEMATIC ANALYSIS

The following is a detailed discussion of the inductive thematic approach used to generate the themes presented in this study. The qualitative data collected underwent the following process. The staff interviews were first read through to sense any patterns or notable occurrences. These patterns or occurrences where then identified, labelled and described. The list of themes generated from this process was entered into a codebook. The interviews were then re-read in order to identify the codes in the raw information. Once the data was coded a matrix was used in order to further organize the codes and interviews in a systematic manner.

According to Miles and Huberman (1994) by using a visual (or display) format that presents the study's data systematically, the researcher can draw valid conclusions and others can follow the intellectual journey that was taken during the thematic analysis. The matrix used for this display was made up of defined rows and columns with data entries being in the form of quotes. Originally the cells contained extended unreduced text which was in the form of quotes from the transcribed interviews with staff. Due to the bulkiness of this approach the text has been condensed but remained focused enough to permit a viewing of the full data set in order to draw and verify valid conclusions by permitting careful comparisons and noting of patterns and themes (Miles & Huberman, 1994).

The portion of the data set/analysis presented here addressed the research question *What does a community based nursing home intermediate care model that seeks to integrate health and social care, voluntary and public sectors look like and what are the key elements of its success?* by focusing on the following specific aim:

- Determine and comment on the impact and effectiveness of the intermediate care model that was used at JON in relation to:

    a. the achievement of the organization's original predetermined success criteria which were categorised as:
    Process (system for sharing service user information);

b. Cross-discipline/cross-agency communication and cooperation (the ability to form and sustain partnerships within the professional teams e.g. the social workers, therapists, nurses, doctors;

Each cell entry is a direct quote that a staff member (identified in the first left hand column) made during their first interview session. During the interview more than one quote may have been pertinent to the theme, in such a case the quotes appear in the cells in order of presentation within the interview, not in order of importance. The following themes emerged from these quotes:

- Pulling care together despite constraints from regulators
- Communication positively viewed at an individual practitioner/carer level
- Communication dysfunctional within and across teams

Table Appendix 11.1 Staff themes

Staff ID	Theme	Sub-category	Narrative
	Pulling care together despite	**Constraints from regulators**	
107			Limited by the CSCI regulations
			It (CSCI)can limit who you can admit
83			CSCI are mainly long stay nursing homes so a lot of their training is geared towards the long stay residents We're sort of out on our own to what training and development we need
			Governing body that doesn't know a lot about intermediate care
94			Their standards are geared to nursing homes

140			Their (CSCI) model (of care), paperwork used in a nursing home…bear in mind that we are rehab
103			All the regulations and all of their training is geared up for the nursing home staff
112			So the paperwork…is all sort of like nursing home paperwork
610			They really haven't got any experience of what we are doing
94			I wouldn't have involved CSCI
111			CSCI don't have their head around that it's different
	Communication	**Positively viewed at an individual practitioner/ carer level**	
112			We got a great training manager
101			(The social workers) are good and supportive
			They (unit nurses) are approachable, you can go to them
103			(We) get on really well with the new guys
			We got the communication going really well
501			Great that they are on site (social workers)
			I really like her as a person
910			(I) work really well with the physio
071			We work (the unit nurses) closely together on the unit
111			We (unit nurses and therapists)have discussions about what's going on
			(We) see each other's point of view regarding sort of patient's care

101			Most of us are on an equal level
			Some excellent members of staff
140			Our physio is quite amazing
			Respect each other's opinion
			A good team spirit
			I communicate very closely with the physiotherapist and the OT
610			On a daily basis…I have an update from them
			They are brilliant at their jobs
			Social workers are fantastic
			Tight little bunch
			Very supportive of one another
			All very caring
103			Medics are…very competent
			What the rehab assistants write is so valuable
83			So good at their jobs
			Started to be open more to each other, it works well
			Working quite well with the physiotherapist
			All very positive in terms of our work
			Got this positiveness in us
			She is good communication wise
			We learn from each other
	Communication	**Dysfunctional within and across teams**	
112			Sending down patients at the moment that are completely inappropriate
			A bit of a brick wall sometimes when you make suggestions
			Handovers are very poor

			Carers don't know half of what's going on
			You're never sure whether things are communicated back and forth
501			They (carers on the unit) don't know important things
			Handovers can be improved
			No one tells us, we don't always know what was said in the meeting
			Very vague information we are given…whether we should look after those patients (referring to the patients admitted under PCT2)
83			This is not clear at the moment(who is assessing the patients at local hospital for potential referral to the unit)
			Communication sometimes within the team…it comes from the top…and nobody knows about it
			I find myself speaking on behalf (of management) Which I don't like much
			The hospital…don't necessarily give a true account of what they 're (patients)like
94			Not working as a team(referring to local hospital referral team and the staff on the unit)
			The carers don't have a handover they go straight to work
			I think we should communicate more(hospital referral staff and unit)
			Whenever there was any suggestions made it was the sort of stone wall
103			We haven't dared ask the nursing…they can't because they haven't been told they can
			The assessment is only as good as the person who has gone to assess them

			The assessments(from the hospital)…they vary that does vary greatly
			Tomorrow it may actually be different
610			Totally inconsistent and there is no rhyme or reason(referring to who gets admitted and who does not)
			A serious power struggle
			Link between the PCT and JON works because the PCT make it work Not because JON make it work
071			It seems very flippant on the assessments of the timescales
			The communication isn't great with the unit
			Everyone does feel that the MDTs are kind of a waste of time at the moment
			It be good if (the unit manager) got on with everybody
			It has stopped the team from gelling as it should
			Be nice if somebody could just say what they want us to do. What the model of care is and everything
801			Be nice…if we know exactly where we stand
			One minute we're ok on something the next minute we're not
			It would have been better to talk about the change at a team meeting
			There is more communication from the Rehab team to the unit than the other way around
			Some communication is hindered by specific personalities
101			Assessments of patients from the County to come here needs to be or could be improved upon

			Not sure they are always given sufficient or appropriate information to bring people down
140			You could have told someone that their relative will not be discharged this week and (the nursing staff) can totally change it and not tell us
			A lot of problems because of bad discharges (when we first got there)
			The relatives and the patients are hearing differ from what we are being told
			It sounds like I am having a moan, but at the end of the day the patients are the ones that are suffering from this, reluctance to work together

Appendix 12

BARTHEL INDEX 100

Feeding

0 = unable

5 = needs help cutting, spreading butter, etc., or requires modified diet

10 = independent

Bathing

0 = dependent

5 = independent (or in shower)

Grooming

0 = needs to help with personal care

5 = independent face/hair/teeth/shaving (implements provided)

Dressing

0 = dependent

5 = needs help but can do about half unaided

10 = independent (including buttons, zips, laces, etc.)

Bowels

0 = incontinent (or needs to be given enemas)

5 = occasional accident

10 = continent

Bladder

0 = incontinent, or catheterized and unable to manage alone

5 = occasional accident

10 = continent

Toilet Use

0 = dependent

5 = needs some help, but can do something alone
10 = independent (on and off, dressing, wiping)

Transfers (bed to chair, and back)

0 = unable, no sitting balance
5 = major help (one or two people, physical), can sit
10 = minor help (verbal or physical)
15 = independent

Mobility (on level surfaces)

0 = immobile or < 50 yards
5 = wheelchair independent, including corners, > 50 yards
10 = walks with help of one person (verbal or physical) > 50 yards
15 = independent (but may use any aid; for example, stick) > 50 yards

Stairs

0 = unable
5 = needs help (verbal, physical, carrying aid)
10 = independent

TOTAL (0–100):

The Barthel ADL Index: Guidelines

1. The index should be used as a record of what a patient does, not as a record of what a patient could do.
2. The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.
3. The need for supervision renders the patient not independent.
4. A patient's performance should be established using the best available evidence. Asking the patient, friends/relatives and nurses are the usual sources, but direct observation and common sense are also important. However direct testing is not needed.
5. Usually the patient's performance over the preceding 24–48 hours is important, but occasionally longer periods will be relevant.
6. Middle categories imply that the patient supplies over 50 per cent of the effort.
7. Use of aids to be independent is allowed.

Appendix 13

SERVICE USER SATISFACTION QUESTIONNAIRE RESPONSES

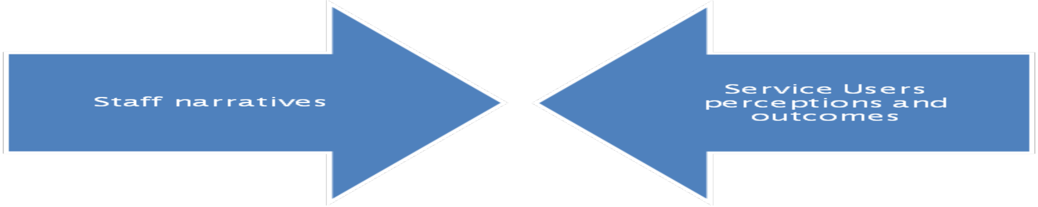
Question	Strongly disagree	Disagree	Don't know	Agree	Strongly agree	Not applicable
The start of my care with the service was very efficiently managed	2(3.4)	4(6.8)	0	47(79.7)	6 (10.2)	0
The service staff were very careful to check everything when they started to provide the service	2 (3.4)	4 (6.8)	3 (5.1)	42 (71.2)	8 (13.6)	0
The team gave me all the information I wanted about my condition	2(3.4)	8 (13.6)	8 (13.6)	39(66.1)	2 (3.4)	0
The team gave me all the information I wanted about the care I was receiving	2(3.4)	5(8.5)	5(8.5)	42(71.2)	5(8.5)	0
I had problems getting pain relief when I needed it	19 (32.2)	25(42.2)	1(1.7)	8(13.6)	3 (5.1)	3(5.1)
I had all the equipment necessary to care for me	4(6.8)	4 (6.8)	0	40 (67.8)	11 (18.6)	0
The team did their best to help me become more independent	1(1.7)	1 (1.7)	0	44(74.6)	13(22)	0
I felt able to talk to the team about any	1(1.7)	9(15.3)	5 (8.5)	40 (67.8)	4 (6.8)	0

problems or worries I had						
The team always had time for me	3 (5.1)	14 (23.7)	3 (5.1)	34 (57.6)	5 (8.5)	0
I have been treated with kindness, respect and dignity by the team from the service	1 (1.7)	1 (1.7)		28 (47.5)	29 (49.2)	0
The team worked together and knew what each other was doing	2 (3.4)	4 (6.8)	8 (13.6)	39 (66.1)	6 (10.2)	0
I was well prepared for when the service finished providing care for me	1 (1.7)	3 (5.1)	14 (23.7)	33 (55.9)	7 (11.9)	1(1.7)
The service finished providing care for me too early	6 (10.2)	20 (33.9)	20 (33.9)	11 (18.6)	2 (3.4)	0
The care I received after the service finished providing care for me was well co-ordinated	0	0	3 (5.1)	3 (5.1)	1 (1.7)	52 (88.1)
The team did everything that they could to make me well again	1(1.7)	1 (1.7)	0	48 (81.4)	9 (15.3)	0
The care I received with the service was just about perfect	1 (1.7)	7 (11.9)	7 (11.9)	36 (61.0)	8(13.6)	0
I'm happy with the amount of recovery I made while being cared for by the service	1 (1.7)	2 (3.4)	2 (3.4)	45 (76.3)	9 (15.3)	0

Appendix 14

CONVERGENT AND DIVERGENT FINDINGS

Convergent findings



Staff

Poor communication with outside referring agencies resulted in inappropriate transfers:

Sending down patients at the moment that are completely inappropriate (ID code 83).

Nowhere near ready (ID code 111).

The hospital doesn't necessarily give a true account of what they're (the patients) like (ID code 801).

Service Users

Quantitative data that converged with this theme:

Out of the 66 participants who had completed data sets, 47 (71.2%) of them had an ALOS >ELOS. With 19 (28.8%) having an ALOS that exceeded the DH's IC imposed 6 weeks time frame.

One service user died whilst being cared for on the unit.

Communication dysfunctional within and across teams	**Quotes that converge with this qualitative theme:**
Handovers are very poor. We are never sure whether things are communicated back and forth (ID code 801).	*I don't think on change-over they get all the information they need. Some of them don't know what I told the staff on before them. It is not passed on or it doesn't seem to be (ID code 241).*
You could have told someone that their relative will not be discharged this week and xx goes and totally changes it without telling you (ID code 610).	*I am writing this on behalf of my mother who is unable to write. My mother thought the facilities/care was very good. I myself felt there was a lack of communication with the various shifts about the things I had asked for my mom and the info was not passed on (ID code 252).*
The carers don't get a handover they go straight to work (ID code 71).	

Poor communication with outside agencies resulted in service users being uninformed as to what to expect from JON:	**Quantitative data that converged with this theme:**
(The SU and their family) think it is a nursing home and we are meant to do everything for them (ID code 101).	Out of 94 service user participants, 9 did not have an ELOS recorded on their transfer sheet. Even though, the protocol was that all service users were to consent in writing to an ELOS and treatment plan prior to transfer.

Poor communication with outside agencies resulted in service users being uninformed as to what to expect from JON con't:

(

(Service users) don't know how things work here (ID code 071).

They (service users) think it is a lovely hotel setting and they can just sit back and relax (ID code 83).

The patients have no idea it is three different groups (ID code 71).

The relatives and the patients are hearing (differently) from what we are being told (referring to hospital's explanation of the care they will receive at JON) (ID code 140).

Quantitative data that converged with this theme cont':

Out of 94 service user participants, 9 did not have an ELOS recorded on their transfer sheet. Even though, the protocol was that all service users were to consent in writing to an ELOS and treatment plan prior to transfer.

Quotes that converge with this theme:

I wasn't looking for anything. I didn't even know the service existed and I didn't know what to expect (ID code 248).

We did not know it was a rehab centre. We were not told that at the hospital (ID code 297).

I really did not know what to expect (ID code 275).

We know nothing about this place (ID code 248).

No information at all from the staff apart from the ones here about the care I would get when I was here. When I am transferred (to the unit from the hospital), we knew nothing about the place (ID code 261).

Physical environment of care: good place to work and conducive to recovery

What's working is the environment (ID code 83).

Comfortable environment with nice facilities and surroundings motivates them (ID code 071).

Geared up for rehab and it’s a lovely building (ID code ID 801).

Quotes that converge with this theme:

The food, the clean towels it was all very special and a special relationship with the night team (ID code 248).

It is a beautiful place (ID code 234).

It’s like a hotel here (ID code 235).

Everything else is beautiful- the building, the rooms, the food (ID code 218).

Positively viewed at an individual practitioner/carer level

You can go to them (nurses) for anything (ID code 103).

They are approachable, you can go to them (PCT therapists) (ID code 111).

Got the communication going really well great that the (PCT)is on site (ID code 140).

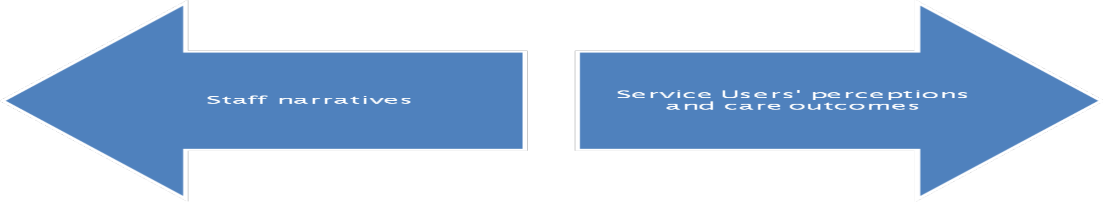
Quotes that converge with this theme:

They always had time for me (ID code 211).

They are very noticing here. I expect their willingness to help and their understanding was the best part of the service here (ID code 220).

They are all very kind (ID code 231).

Divergent findings



Staff comments indicated that:

There were many issues impeding the team from delivering quality intermediate care. The predominant themes are listed below with supporting quotes.

Constraints from the CSCI regulator

Governing body that doesn't know a lot about intermediate care (ID code 83).

CSCI are mainly long stay nursing homes so a lot of their training is geared towards the long stay residents. We're sort of out on our own to what training and development we need (ID code 107).

All their (CSCI) standards are geared to nursing homes...So the paperwork is used in a nursing home (ID code 94 & 140).

CSCI focuses on long term care policies such as monthly versus daily assessments and long term charting and paper work that don't even have a spot for the doctor's name (ID code 112).

Quantitative data indicated that:

The majority of the service users on the unit received quality intermediate care and improved functionally and returned home. The supporting data for this conclusion is presented below.

At the time of discharge out of 85 service users, 63 (74.1%) returned to the home in which they were residing prior to this episode of care.

Out of the 75 services users with completed data sets 66 (88.0%) improved functionally (as measured by the Barthel Index 100). The mean increase in Barthel Index 100 score was 24.3.

The following are qualitative examples from the thematic analysis of the semi-structured discharge interviews (n=59). Accompanying these, are the responses from the satisfaction questionnaires and the free text comments which indicate the majority of service users at JON had a positive intermediate care experience.

Uncertainly about the vision of JON's IC unit

(The JON foundation) no perception on what it is we are trying to achieve I just feel it's a rehab unit (ID code 94).

We have different employers and those employers have different aims (ID code 103).

There is issues of what (is) intermediate care is and what is rehab (ID code 610).

It is very much like a nursing home (ID code 801).

I think it is a rehabilitation unit (ID code 910).

Uncertainty about the model of care being provided at JON

When asked what model was being implemented on the unit, staff replied:

Suppose we have developed our own model (ID code 140).

I don't think a model has ever been discussed (ID code 112).

Some of the nurses are going by what they did in hospital. People who worked in nursing homes are going by nursing home (models) (ID code 101).

No model really. We really improvise most of the time (ID code 801).

Thematic analysis of discharge semi-structured interviews

The findings from the thematic analysis of the discharge interviews indicated, on the whole, that service users were satisfied with the care they received and the staff treated them with respect whilst meeting their intermediate care needs (e.g. assisting them to improve functionally and organizing more care at home as need be).

Satisfaction questionnaire

The quantitative analysis of the satisfaction questionnaires (n=59) revealed that the following % of service users agreed or strongly agreed that:

89.9% The start of my care with the service was very well managed.

91.6% I'm happy with the amount of recovery I made while being cared for by the service.

69.5% The team gave me all the information I wanted about my condition.

79.7% The team gave me all the information I wanted about the care I was receiving.

76.3% The team worked together and knew what each other was doing.

67.8% I was well prepared for when the

Professional judgements being disregarded

Decisions that are made in that meeting (the weekly MDT) can be overruled out of the meeting. Overrule them without telling anybody. I'm embarrassed it is unprofessional and it is wrong. Chips away at the service we are giving (ID code 140).

It will be documented. Everybody knows their goals. It is all clear. But within minutes it's actually changed. You are not told until you just happen to find out (ID code 610).

One minute we're OK on something the next minute we're not (ID code 801).

Fragmentation within the multidisciplinary team

You are divided by who employs you (ID code 71).

Your doctors and mangers would be at the top and then you got your PCT and the qualified nurses…the care assistants get kind of down at the bottom (ID code 101).

Carers don't know half of what's going on (ID code 101).

Dysfunctional within and across teams

Everyone does feel that the MDTs are kind

service finished providing care for me.

96.7% The team did everything that they could to make me well again.

74.6% I felt able to talk to the team about any problems or worries I had.

86.4% I had all the equipment necessary to care for me.

96.6% The team did their best to help me become more independent.

96.7% I have been treated with kindness, respect and dignity by the team from the service.
(See Appendix 13 for the questionnaire responses in its entirety).

The following comments, from the free text and the semi-structured interviews, support the above stated statistics:

Yes by all means (the service provided what I wanted it to). Everything helped me. They are so lovely here; it is a beautiful place (ID code 234).

I agree with every word I own. I think the confusion was due to the hospital rather than JON. I complained to the person in charge and they rectified it (ID code 261).

They've helped me with my independence. I was fairly independent before I was hospitalized and they got me pretty close to that again (ID code 214).

of a waste of time at the moment (ID code 83).

I can't rely on the fact that (staff within the MDT) have done it (followed through with decisions made in the MDT). It is quite frustrating and it's not safe (ID code 140).

Not working as a team... reluctance to work together (ID codes 801).

A serious power struggle...totally inconsistent and there is no rhyme or reason (ID code 610).

Insufficient equipment to provide care

Limited to what they (physio) can do because they don't have any equipment (ID code 610).

Arguments about who paid for what or pays for what still run a long to date (ID code 103).

Autocratic leadership

The following amalgamation of quotes refer to the staff comments that focused on an autocratic leadership style dominating the unit.

People won't question authority on this unit... There is no autonomy on this unit...it is removing any authority that (staff) have...the confidence of the nurses is undermined...tried to undermine our confidence as a team...They are afraid

You have done wonders for me it has been wonderful. They are all such a lovely bunch, they really are. They did it all to help me in the beginning now I'm doing it for myself (ID code 238).

I am glad to be going home. Have done everything I needed (ID code 254).

They are very noticing here. I expect their willingness to help and their understanding was the best part of the service here (ID code 221).

Yes, I've done exercises and they made me walk. They left me alone and gave me my privacy and it made me walk to the dining room 3 times a day (ID code 225).

I feel settled and secure for the first time in quite a while. They seem to know what they are doing around here, very efficient (ID code 221).

I was very pleased with what (staff) have done (ID code 255).

It has cared for all my needs (ID code 258).

Because they have all been attentive wonderful girls I walk about around here (ID code 263).

I am ready to go home. I do feel more confident (ID code 265).

Yes I must admit it gave me my confidence back again which, I lost through falling (ID code 268).

(nurses on the unit) to make decisions therefore, they are not having enough impute into ideas….very reticent and very scared and will be very careful what they (staff nurses) say (ID codes 501, 112, 94, 103, 140, 111).

I am very happy with the strength I now have. It is surprising how quick time has gone. It is 6 weeks all together; it doesn't seem possible (ID code 270).

I still have pain, that's it really. I have help at home now. The girls will come in to help my wife (ID code 280).

I am very pleased to be going home, it was all I wanted (ID code 281).

References

Adami, M. F., & Kiger, A. 2005, 'The use of triangulation for completeness purposes', Nurse Researcher, vol. 12, no. 4, pp. 19-29.

Andrews, J., Manthorpe, J., & Watson, R. 2004, 'Involving older people in intermediate care', Journal of Advanced Nursing, vol. 46, no. 3, pp. 303–310.

Angle, H. 1989, 'Psychology and organizational innovation', in Research on the management of innovation: The Minnesota studies A. Van de Ven, H. Angle, & M. Poole eds., Harper & Row, New York, pp. 135-170.

Appleton, J. 2002, 'Critiquing approaches to case study design for a constructivist inquiry', Qualitative Research Journal, vol.2, no.2, pp. 80–97.

Arrow, H., McGrath, J. E., & Berdahl, J. l. 2002, Small groups as Complex Systems: Formation, Coordination, Development, and Adaptation, SAGE Publications, London.

Audit Commission (AC), 1992, Lying in Wait: the use of medical beds in acute hospitals. National Health Service Report No 5 1992, London.

Audit Commission (AC), 1997, The Coming of Age. Improving care services for older people (national report), Audit Commission Publications, London

Audit Commission (AC), 2000, The way to go home. Rehabilitation and remedial services for older people. Audit Commission Publications, London.

Baldwin, R. 2003, 'National Service Framework for Older People', The Psychiatrist, vol. 27, no. 4, pp. 121–122.

Barton, P., Bryan, S., Glasby, J., Hewitt, G., Jagger, C., Kaambwa, B., Martin, G., Nancarrow, S., Parker, H., Parker, S., Regen, E., & Wilson, A. 2006, A National Evaluation of the Costs and Outcomes of Intermediate Care for Older People, The University of Birmingham and The University of Leicester, Birmingham & Leicester.

Beech, R., Russell, W., Little, R., & Sherlow-Jones, S. 2004, 'An evaluation of a multidisciplinary team for intermediate care at home', International Journal of Integrated Care, vol. 4, pp. 1-10.

Bolton, S. 2000, 'Who cares? Offering emotion work as a gift in the nursing labour process', Journal of Advanced Nursing, vol. 32, no. 3, pp. 580-586.

Bone, R. C., McElwee, N. E., Eubanks, D. H., & Gluck, E. H. 1993, 'Analysis of indications for early discharge from the intensive care unit. Clinical efficacy assessment project: American College of Physicians', Chest, vol. 104, pp. 1812-1817.

Bono, J. & Vey, M. 2005, 'Towards Understanding Emotional Management at Work: A Quantitative Review of Emotional Labor Research,' in Emotions in Organizational Behavior, C. E. J. Hartel, W. J. Zerbe, & N. M. Ashkanasy, eds., Lawrence Erlbaum Associates Inc Publishers, New Jersey.

Boyatzis, R. 1998, Transforming Qualitative information: Thematic Analysis and Code Development, SAGE Publications, London.

Bryman, A. 2007, 'Barriers to Integrating Quantitative and Qualitative Research', Journal of Mixed Methods Research, vol. 1, no. 1, pp. 8-22.

Calsyn, R. J. & Winter, J. P. 1999, 'Understanding and Controlling Response Bias in Needs Assessment Studies', Evaluation Review, vol. 23, no. 4, pp. 399-417.

Carpenter, I., Gladman, J., Parker, G., & Potter, J. 2002, ‘Clinical and research challenges of intermediate care’, Age and Ageing, vol. 31, no. 2, pp. 97-100.

Carpenter, I., Challiner, Y., Coxon, K., Kotiadis, K., & Mackenzie, M. 2005, An Evaluation of Intermediate Care Services for Older People: Intermediate Care Organization & Normalisation, Centre for Health Services Studies, University of Kent, Kent.

Coffey, A. 2006, ‘Discharge older people from hospital to home: what do we know?’, International Journal of Older People Nursing, vol. 1, pp. 141-150.

Coffey, A., Atkinson, P., 1996. Making Sense of Qualitative Data. Complementary Research Strategies. SAGE Publications, London.

Collin, C., Wade, D., Davies, S., & Horne, V. 1988, ‘The Barthel ADL Index: A reliability study’, International disability studies, vol. 10, no. 2, pp. 61-63.

Commission for Social Care inspection (CSCI) 2006, Care Homes for Older People Guidance Log, CSCI: Quality, Performance & Methods Directorate, London, QPM DOC

Coulter, A., Entwistle, V., & Gilbert, D. 1999, ‘Sharing decisions with patients: is the information good enough?’, BMJ, vol. 318, no. 7179, pp. 318-322.

Creswell, J. & Miller, D. 2000, ‘Determining validity in qualitative inquiry’, Theory into Practice, vol. 39, no. 3, pp. 124-131.

Creswell, J. 2003, Research Design. Qualitative, Quantitative, and Mixed Methods Approaches, 2nd ed, SAGE Publications, London.

Creswell, J., Plano Clark, V., Gutman, M., & Hanson, W. 2003, 'Advanced Mixed Methods Research Design,' in Handbook of Mixed Methods in Social & Behavioral Research, A. Tashakkori & C. Teddlie, eds., SAGE Publications, London, pp. 209-240.

Creswell, J. 2007, Qualitative Inquiry and Research Design: Choosing Among Five Approaches, 2nd ed, SAGE Publications, London.

Crotty, M. 1998, The Foundations of Social Research: Meaning and perspective in the Research Process, SAGE Publications, London.

Crombie, I. K. 1996, The Pocket Guide to Critical Appraisal, BMJ Publishing Group, London.

Cummings, T. & Worley, C. 2001. Organization Development and Change, Thomson South- Western, Mason, OH.

Denzin, N. 1970, The research act: A theoretical introduction to sociological methods, Aldine, Chicago.

Denzin, N 1990, 'The Many Faces of Emotionality: Reading Persona', in Investigating subjectivity: research on lived experience. C. Ellis, & M. C. Flaherty eds., SAGE Publications, London pp. 17- 30.

Denzin, N. & Lincoln, Y. 1998, Collecting and Interpreting Qualitative Materials, SAGE Publications, London.

Denzin, N. & Lincoln, Y. 2005 Handbook of Qualitative Research, SAGE Publications, Thousand Oaks.

Department of Health and Social Security (DHSS), 1973, Report of the working party on collaboration between the NHS and local government. HMSO, London.

Department of Health, 1996, Priorities and planning guidance for the NHS: 1996/1997, HMSO, London.

Department of Health, 1997, Better Services for Vulnerable People, HMSO, London.

Department of Health, 1997a, Rehabilitation - a guide, HMSO, London.

Department of Health, 1998a, Second Report from the Emergency Services Action Team (ESAT), HMSON, London.

Department of Health, 1998, National Bed Inquiry- winter pressures, HMSO, London.

Department of Health, 1999, Making a difference. Strengthening the nursing, midwifery and health visiting contribution to health and healthcare, HMSO, London.

Department of Health, 1999a, The Health Act: partnership arrangements regulations, HMSO, London.

Department of Health, 2000, Shaping the Future NHS: Long Term Planning for Hospitals and Related Services. Consultation Document on the Findings of The National Beds Inquiry. HMSO, London.

Department of Health, 2000a, Shaping the Future NHS: Long Term Planning for Hospitals and Related Services. Consultation Document on the Findings of The National Beds Inquiry Supporting analysis, HMSO, London.

Department of Health, 2000b, The NHS Plan, HMSO, London.

Department of Health, 2001, Modern Standards and Service Models for Older People: National Service Framework for Older People. HMSO, London.

Department of Health, 2001, Health Services Circular, Local Authority Circular: Intermediate Care, Department of Health, London, HSC 2001/01: LAC (2001)1.

Department of Health, 2002, National Service Framework for Older People. Supporting Implementation. Intermediate Care: Moving Forward, Department of Health, London.

Department of Health 2002a, The Single Assessment Process: Guidance for local implementation. HMSO, London.

Department of Health, 2004a, (CAT) Changing times. Improving services for older people; report on the work of the health and social care change agent team 2003/2004,

Department of Health, London.

Department of Health, 2004, National Standards, Local Action. Health and Social care Standards and Planning Framework, Department of Health, London, gateway ref:3533.

Department of Health, 2006, A New Ambition for Older People- Next steps in Implementing the National Service Framework for Older People, Department of Health, London, gateway reference 5601.

Dixon, S., Kaambwa, B., Nancorrow, S., Martin, G., Bryan, S. 2010, 'The relationship between staff skill mix, costs and outcomes in intermediate care services', BMC Health Services Research, vol 10, pp. 221-228.

Dowling, B., Powell, M., & Glendinning, C. 2004, 'Conceptualising successful partnerships', Health & Social Care in the Community, vol. 12, no. 4, pp. 309–317.

Eisner, E. 1985, 'Aesthetic Modes of Knowing,' in Learning and Teaching the Ways of Knowing: Eighty-four year book of the National Society for the Study of Education, Eisner, ed., National Society of the Study of Education, Chicago, pp. 23–36.

Enderby, P. & Stevenson, J. 2000, 'What is Intermediate care? Looking at Needs', Managing Community Care, vol. 8, no. 6, pp. 35–40.

Ernest, P. 1995. 'The one and the many', in Constructivism in education, L. Steffe & J. Gale, eds., Lawrence Erlbaum Associates, Inc, New Jersey, pp.459-486.

Erzberger, C. & Kelle, U. 2003, 'Making Inferences in Mixed methods: The Rules of Integration,' in Handbook of Mixed Methods in Social & Behavioral Research, A. Tashakkori & C. Teddlie, eds., SAGE Publications, London, pp. 457–490.

Fineman, S. 1993, Emotion in Organizations, SAGE Publications, London.

Fisher, C. 2005, Qualitative research methods for psychologists: Introduction through empirical studies, Academic Press: New York.

Flick, U. 1998, An introduction to qualitative research, SAGE Publications, London.

Geertz, C. 1973, The interpretation of cultures: selected essays, Basic Books, Inc., New York.

Glendinning, C., Rummery K & Clarke R, 1998, 'From Collaboration to commissioning: developing relationships between primary health and social services', BMJ: British Medical Journal, vol. 317 pp. 122-125.

Glendinning, C., Coleman, A., Shipman, C., Malbon, G. 2001, 'Primary care groups; Progress in Partnerships', BMJ: British Medical Journal, vol 323 pp. 28-31.

Glendinning, C. & Rummery, K. 2003, 'Collaboration between primary health and social care: From policy to practice in developing services for older people,' in Interprofessional Collaboration: From Policy to Practice in Health and Social Care, A. Leathard, ed., Brunner- Routledge, Hove, pp. 186-199.

Glomb, T. M. & Tews, M. J. 2004, 'Emotional labor: A conceptualization and scale development', Journal of Vocational Behavior, vol. 64, no. 1, pp. 1-23.

Godfrey, M., Keen, J., Townsend, J., Moore, J., Ware, P., Hardy, B., West, R., Weatherly, H., & Henderson, K. 2005, An Evaluation of Intermediate Care for Older People, Final Report, Institute of Health Sciences and Public Health Research, University of Leeds, Leeds.

Golden- Biddle, K. & Locke, K. 1993, 'Appealing Work: An investigation of how ethnographic texts convince', Organization Science, vol. 4, pp. 595-616.

Goodwin, N. 2001, 'The long term importance of English primary care groups for integration in primary health care and deinstitutionalisation of hospital care' International Journal of Integrated Care, vol.1, pp.1-10.

Gomm,R., Hammersley, M., & Foster, P, 2000, Case Study Methods, SAGE Publications, London.

Grandey, A. 2000, ‘Emotion Regulation in the Workplace: A New Way to Conceptualise Emotional Labor’, Journal of Occupational Health Psychology, vol. 5, no. 1, pp. 95-110.

Gray, B. 2002, ‘Emotional labour and befriending in family support and child protection in Tower Hamlets’, Child & Family Social Work, vol. 7, no. 1, pp. 13-22.

Gray, B. 2009, ‘The emotional labour of nursing - Defining and managing emotions in nursing work’, Nurse Education Today, vol. 29, no. 2, pp. 168-175.

Gray, B. & Smith, P. 2009, ‘Emotional labour and the clinical settings of nursing care: The perspectives of nurses in East London’, Nurse Education in Practice, vol. 9, no. 4, pp. 253-261.

Green, J., Caracelli, V., & Graham, W., 1989, ‘Towards a conceptual framework for mixed-method evaluation design’, Educational Evaluation and Policy Analysis, vol. 11, pp.255-247.

Green, J., Young, J., Forster, A., Mallinder, K., Bogle, S., Lowson, K., & Small, N. 2005, ‘Effects of locality based community hospital care on independence in older people needing rehabilitation: Randomized controlled trial’, BMJ, vol. 331, no. 7512, pp. 317-322.

Gresham, G., Labi, M., & Phillips, T. 1980, ‘ADL status in stroke: relative merits of three standard indexes’, Archives of physical medicine and rehabilitation, vol. 61, pp. 355-358.

Griffiths, P. 2002, ‘Nursing-led in-patient units for intermediate care: a survey of multidisciplinary discharge planning practice’, Journal of Clinical Nursing, vol. 11, no. 3, pp. 322-330.

Griffiths P., Edwards M., Forbes A., Harris G., Ritchie G. 2009, 'Effectiveness of intermediate care in nursing-led in-patient units (Review'). Cochrane Database of Systematic Reviews Issue 1.

Griffiths, P. 2010, 'Intermediate care in nursing-led units - a comprehensive overview of the evidence base', Reviews in Clinical Gerontology, vol. 16, pp. 71–77.

Griffiths, P., Wilson-Barnett, J., Richardson, G., Spilsbury, K., Miller, F., & Harris, R. 2000, 'The effectiveness of intermediate care in a nursing-led in-patient unit', International Journal of Nursing Studies, vol. 37, no. 2, pp. 153–161.

Griffiths, P., Harris, R., Richardson, G., Hallett, N., Heard, S., & Wilson-Barnett, J. 2001, 'Substitution of a nursing-led inpatient unit for acute services: randomized controlled trial of outcomes and cost of nursing-led intermediate care', Age and Ageing, vol. 30, no. 6, pp. 483–488.

Griffiths, P., Edwards, M., Forbes, A., & Harris, R. 2005, 'Post-acute intermediate care in nursing-led units: a systematic review of effectiveness', International Journal of Nursing Studies, vol. 42, no. 1, pp. 107–116.

Guba, E, & Lincoln, Y, 1989, 'Judging the quality of fourth generation evaluation, in Fourth generation evaluation, E. Guba, & Y. Lincoln SAGE Publications, Newbury Park, CA, pp. 228-51.

Halcomb, E. & Andrew, S. 2005, 'Triangulation as a method for contemporary nursing research', Nursing Researcher, vol. 13, no. 2, pp. 71–79.

Hartel, C. E. J., Ashkanasy, N. M., & Zerbe, W. J. 2007, Research on Emotion in Organizations, ELSEVIER, London.

Health and Social Care Chance Agent Team (CAT). Evaluating Intermediate Care-briefing papers. Care Service Improvement Partnership (CSIP). 2007. Ref Type: Electronic Citation

Help the Aged (HTA), 2000, Health and Older People & Help the Aged, Our Future Health: Older people's priorities for health and social care, Help the Aged.

Help the Aged (HTA), 2001, Intermediate Care, Help the Aged.

Help the Aged (HTA), 2004, Meeting Care Needs in the Community: Help the Aged Policy Statement, Help the Aged.

Hobart, J. C. & Thompson, A. J. 2001, 'The five item Barthel index', Journal of Neurology, Neurosurgery, and Psychiatry, vol. 71, no. 2, pp. 225-230.

Hochschild, A. 1983, The Managed Heart: Commercialisation of Human Feeling. University of California Press, Berkeley CA.

Hochschild, A. R. 1979, 'Emotion Work, Feeling Rules, and Social Structure', American Journal of Sociology, vol. 85, no. 3, p. 551.

Hsueh, I. P., Lin, J. H., Jeng, J. S., & Hsieh, C. L. 2002, 'Comparison of the psychometric characteristics of the functional independence measure, 5 item Barthel Index, and 10 item Barthel Index in patients with stroke', Journal of Neurology, Neurosurgery, and Psychiatry, vol. 73, no. 2, pp. 188-190.

Hudson, B. 1999, 'Joint commissioning across the primary health care-social care boundary: can it work?', Health and Social Care in the Community, vol. 7, no. 5, pp. 358-366.

Hudson B., Hardy B., Henwood M. & Wistow G. 1999, 'In pursuit of inter-agency collaboration in the public sector', Public Management, vol.1, pp. 235-260.

Hudson, B. 2006, 'Policy change and policy dilemmas: interpreting the community services White Paper in England', International Journal of Integrated Care, vol. 6, no. 17.

Humphris, D.2007, Multiprofessional working, interprofessional learning and primary care: a way forward? Contemporary Nurse, vol. 26, no. 1, pp. 48-55.

James, N. 1992, 'Care = organisation + physical labour + emotional labour', Sociology of Health & Illness, vol. 14, no. 4, pp. 488-509.

Johnson, R. B. 1997, 'Examining the validity structure of qualitative research', Education, vol. 118, no. 3, pp. 282-292.

Johnson, S. D., Suriya, C., Won Yoon, S., Berrett, J. V., & La Fleur, J. 2002, 'Team development and group processes of virtual learning teams', Computers & Education, vol. 39, no. 4, pp. 379-393.

Johnson, R., Onwuegbuzie, A., & Turner, L. 2007, 'Towards a definition of mixed methods research', Journal of Mixed Methods Research, vol. 1, no. 2, pp. 112-133.

JON 2006, JON Annual Review: Community...a sense of belonging, JON, UK.

Jones, J. 1999, 'Economic evaluation of hospital at home versus hospital care: cost minimisation analysis of data from a randomised controlled trial', British Medical Journal, vol. 319, pp. 1574-1550.

Jordan, P. and Troth, A. 2006 'Emotions and coping with conflict: An introduction', Journal of Management & Organization, vol. 12 no.2, pp. 98-100.

Kaambwa, B., Bryan, S., Barton, P., Parker, H., Martin, G., Hewitt, G. J., Parker, S., & Wilson, A. 2008, 'Costs and health outcomes of intermediate care: results from five UK case study sites', Health and Social Care in the Community, vol. 16, no. 6, pp. 573–581.

Kaplan, R. & Norton, D. 1996, The Balanced Scorecard: Translating Strategy into Action Harvard Business School Press, USA.

Keen, J. & Packwood, T. 1995, 'Qualitative Research: Case study evaluation', BMJ, vol. 311, no. 7002, pp. 444–446.

Kinsella, K. & Velkoff, V. A. 2001, 7 A.D., An Aging World: 2001 International Population Reports. U.S. Government Printing Office, Washington, DC, USA.

Kvale, S.1996, Interviews: an introduction to qualitative research interviewing, SAGE, Thousand Oaks.

Leathard, A. 2003, Interprofessional Collaboration: From Policy to Practice in Health and Social Care, Brunner- Rutledge, Hove.

Levi, D. 2010, Group Dynamics for Teams, SAGE Publications Ltd, London.

Lincoln, Y., & Guba, E. 2005, Handbook of Qualitative Research, SAGE Publications Inc, Thousand Oaks.

Lincoln, Y. & Guba E. 2007, 'The Only Generalization is: there is No Generalization,' in Case Study Method, R. Gomm, M. Hammersley, & P. Foster, eds., SAGE Publications, Ltd, London.

Lymbery, M. 1998, ‘Care Management and Professional Autonomy: The Impact of Community Care Legislation on Social Work with Older People’, British Journal of Social Work, vol. 28 no. 6, pp. 863-878.

Lomas, J. 2003, ‘Health services research: More lessons from Kaiser Permanente and Veterans' Affairs healthcare system’, BMJ, vol. 327, pp. 1301–1302.

Loxley, A. 1997, Collaboration in health and welfare: Working with difference , Jessica Kingsley, London.

MacMahon, D. 2001, ‘Intermediate care--a challenge to specialty of geriatric medicine or its renaissance?’, Age and Ageing, vol. 30, no. suppl_3, pp. 19–23.

MacNeill, S. E. & Lichtenberg, P. A. 1998, ‘Predictors for Functional Outcome in Older Patients’, The International Journal of Psychosocial Rehabilitation, vol. 43, no. 3, pp. 246–257.

Mahoney, F. I. & Barthel, D. W. 1965, ‘Functional Evaluation: The Barthel Index.’, Maryland State Medical Journal, vol. 14, p. 56.

Manthorpe, J. 2006, 'Policy Developments in the Organization of Support for Older People', in Nursing Older People, S. J. Redfern & F. M. Ross eds, Churchill Livingstone: Edinburgh, pp. 85-102.

Martin, G. P., Hewitt, G. J., Faulkner, T. A., & Parker, H. 2007, ‘The organisation, form and function of intermediate care services and systems in England: results from a national survey’, Health & Social Care in the Community, vol. 15, no. 2, pp. 146–154.

Martin, G. P., Peet, S. M., Hewitt, G. J., & Parker, H. 2004, ‘Diversity in intermediate care’, Health & Social Care in the Community, vol. 12, no. 2, pp. 150–154.

Mason, J. 2007, Qualitative Research, 2 ed, SAGE publications Ltd, London.

Mayhew, L. & Lawrence, D. 2006, 'The costs and service implications of substituting intermediate care for acute hospital care', Health Services Management Research, vol. 19, no. 2, pp. 80-93.

McClure, R. & Murphy, C. 2007, 'Contesting the dominance of emotional labour in professional nursing', Journal of Health Organization and Management, vol. 21, no. 2, pp. 101.

McColl, E., Jacoby, A., Thomas, L., Soutter, J., Bamford, C., Steen, N., Thomas, R., Harvey, E., Garratt, A., & Bond, J., 2001, 'Design and use of questionnaires: a review of best practice applicable to surveys of health service staff and patients', Health Technology Assessment NHS R&D HTA Programme, HTA. 5, no. 31.

McCormack, B. 2003, 'A conceptual framework for person-centred practice with older people', International Journal of Nursing Practice, vol. 9, pp. 202-209.

McCormack, B. 2004, 'Person-centredness in gerontological nursing: an overview of the literature', International Journal for Older People Nursing, vol. 13, no. 3a, pp. 31-38.

McCormack, B., & McCance, T. 2006, ' Development of a framework for person-centred nursing', Journal of Advanced Nursing, vol. 56, no. 5, pp. 472-479.

Melis, R. J. F., Olde Rikkert, M. G. M., Parker, S. G., & van Eijken, M. I. J. 2004, 'What is intermediate care? An international consensus on what constitutes intermediate care is needed', BMJ, vol. 329, pp. 360-361.

Mertens, D. M. 2003, 'Mixed Methods and the Politics of Human Research: The Transformative-Emancipator Perspective,' in Handbook of Mixed Methods In Social and Behavioural Research, A. Tashakkori & C. Teddlie, eds., SAGE Publications, London, pp. 111-134.

Miles, M. B. & Huberman, A. M. 1994, An Expanded Sourcebook: Qualitative Data Analysis, 2nd edn, SAGE publications, Inc, London.

Moore, J., West, R. M., Keen, J., Godfrey, M., & Townsend, J. 2007, 'Networks and governance: the case of intermediate care', Health & Social Care in the Community, vol. 15, no. 2, pp. 155-164.

Mohrman, S, Cohen, S, & Mohrman, A. Jr., 1995, Designing team-based organizations:

Newforms for knowledge work, Jossey- Bass, San Francisco.

Nancarrow, S. 2004, 'Improving intermediate care: giving practitioners a voice', Journal of Integrated Care, vol. 12, no. 1, pp. 33-41.

Nancarrow, S. 2007, 'The impact of intermediate care services on job satisfaction, skills and career development opportunities', Journal of Clinical Nursing, vol. 16, no. 7, pp. 1222-1229.

The National Institute for Health Research Service Delivery and Organisation. (NIHRSDO). The National Institute for Health Research Services Delivery and Organization. 2010. NHS. http://www.sdo.nihr.ac.uk/Ref Type: Electronic Citation

Nocon, A., & Balwin, S. 1998, Trends in rehabilitation policy: A review of the literature, The King's fund: London.

Nolan, M., Davies, S., Brown, J., Keady J., & Nolan, J. 2004, 'Beyond 'person-centred' care: a new vision for gerontological nursing', International Journal for Older People Nursing, vol. 13, no. 13a, pp. 45-53.

Onwuegbuzie, A, & Teddlie, C. 2003, 'A framework for Analysing Data' in Handbook of Mixed Methods in Social and Behavioural Research, A. Tashakkori & C. Teddlie, eds., SAGE Publications, London, pp. 351-384.

Outhwaite, W. & Turner, S. 2007, The SAGE Handbook of Social Science Methodology, SAGE Publications Ltd, London.

Oxford English Dictionary. Oxford English Dictionary. Oxford English Dictionary. 2007.
Ref Type: Electronic Citation

Parker, S., Oliver, P., Pennington, M., Jagger, C., Enderby, P., Curless, R., Chater, T., Vanoli, A., Fryer, K., Cooper, C., Julious, S., Donaldson, C., Dyer, c., Wynn, T., John, A., & Ross, D. 2009, 'Rehabilitation of older patients: day hospital compared with rehabilitation at home: A randomised controlled trial', Health Technology Assessment vol. 13, pp. 39.

Patton, M. 1986. Utilization-Focused Evaluation. 2nd ed., SAGE Publications: Newbury Park, CA.

Pawson, R. & Tilley, N. 1997, Realistic Evaluation SAGE Publications, London.

Pencheon, D. 2002, 'Intermediate care - appealing and logical, but still in need of evaluation', BMJ, vol. 324, pp. 1347-1348.

Phillips, D. L. & Clancy, K. J. 1970, 'Response Biases in Field Studies of Mental Illness', American Sociological Review, vol. 35, no. 3, pp. 503-515.

Philp, I. 2002, 'Developing a National Service Framework for older people', Journal of Epidemiology and Community Health, vol. 56, no. 11, pp. 841-842.

Plano Clark, V. & Creswell, J. 2010, Designing and Conducting Mixed Methods Research Sage Publications, London.

Platt, J. 2007, 'Case Study,' in The SAGE Handbook of Social Science Methodology, W. Outhwaite & S. Turner, eds., SAGE Publications Ltd, London, pp. 100-118.

Plochg, T., Delnoij, D., van der Kruk, T., Janmaat, T., & Klazinga, N. 2005, 'Intermediate care: for better or worse? Process evaluation of an intermediate care model between a university hospital and a residential home', BMC Health Services Research, vol. 5, no. 1, p. 38.

Pollock, A. M. 2000, 'Will intermediate care be the undoing of the NHS?', BMJ, vol. 321, no. 7258, pp. 393-394.

Pope, C. & Mays, M. 2006, Qualitative research in health care, Blackwell/BMJ Books, Oxford.

Putman, L. L. & Mumby, D. K. 1993, 'Organizations, emotion and the myth of rationality,' in Emotion in Organizations, S. Fineman, ed., Sage Publications Ltd, London.

Rallis, S. & Rossman, G. 2003, 'Mixed Methods in Evaluation Contexts: A Pragmatic Framework,' in Handbook of Mixed Methods in Social & Behavioral Research, A.

Tashakkori & C. Teddlie, eds., Sage Publications, Inc, London, pp. 491-512.

Ray, R. A. & Street, A. F. 2005, ‘Ecomapping: an innovative research tool for nurses’, Journal of Advanced Nursing, vol. 50, no. 5, pp. 545-552.

Redfern, S., Hannan, S., Norman, I., & Martin, F. 2002, ‘Work satisfaction, stress, quality of care and morale of older people in a nursing home’, Health & Social Care in the Community, vol. 10, no. 6, pp. 512-517.

Redfern, S. 2006, Nursing Older People, 4th edn, Elsevier Churchill Livingstone, Edinburgh.

Regen, E., Martin, G., Glasby, J., Hewitt, G., Nancarrow, S., & Parker, H. 2008, ‘Challenges, benefits and weaknesses of intermediate care: results from five UK case study sites’, Health & Social Care in the Community, vol. 16, no. 6, pp. 629-637.

Reis Miranda, D., de Rijk, A., & Schaufeli, W. 1996, ‘Simplified therapeutic intervention scoring system: the TISS-28 items - results from a multicenter study’, Crit Care Med, vol. 24, pp. 64-73.

Richardson, G., Griffiths, P., Wilson-Barnett, J., Spilsbury, K., & Batehup, L. 2001, ‘Economic Evaluation of a nursing-led intermediate care unit’, International Journal of Technology Assessment in Health Care, vol. 17, no. 03, pp. 442-450.

Ridly, S. A. 1998, ‘Intermediate care. Possibilities, requirements and solutions’, Anaesthesia, vol. 53, pp. 654-664.

Robinson, J., & Turnock, S. 1998, Investing in rehabilitation, King's Fund Publishing, London.

Robinson, K. A., Dennison, C. R., Wayman, D. M., Pronovost, P. J., & Needham, D. M. 2007, 'Systematic review identifies number of strategies important for retaining study participants', Journal of Clinical Epidemiology, vol. 60, no. 8, p. 757.

Roe, B., Daly, S., Shenton, G., & Lochhead, Y. 2003, 'Development and evaluation of intermediate care', Journal of Clinical Nursing, vol. 12, no. 3, pp. 341-350.

Roemer, M. I. 1961, 'Bed supply and utilization: a natural experiment', Hospitals: J Am Hosp Ass, vol. 35, pp. 35-42.

Rogers, E. M. 1995, Diffusion of innovations (4th edn.), Free Press, New York.

Ross, C. E. & Mirowsky, J. 1984, 'Socially-Desirable Response and Acquiescence in a Cross-Cultural Survey of Mental Health', Journal of Health and Social Behavior, vol. 25, no. 2, pp. 189-197.

Rossman, G. B. & Wilson, B. L. 1985, 'Numbers and words: Combining quantitative and qualitative methods in a single-scale evaluation study', Evaluation Review, vol. 5, pp. 627-643.

Rummery, K. & Glendinning, C. 2000, Primary Care and Social Services: Developing New Partnerships for Older People, Radcliff Medical Press, Oxford.

Russell W., Beech, R., & Little R. 2007, 'Developing a strategy for the evaluation of intermediate care services: Issues, questions and performance measures', The international Journal of Integrated Care. Ref Type: Electronic Citation

Ryan, F., Coughlan, M., Cronin, P., 2007 British Journal of Nursing, Vol. 16, Iss. 12, pp. 738 - 744.

Sainsbury, A., Seebass, G., Bansal, A., & Young, J. B. 2005, 'Reliability of the Barthel Index when used with older people', Age and Ageing, vol. 34, no. 3, pp. 228-232.

Sandelowski, M. 2003, 'Tables or Tableaux? The Challenges of Writing and Reading Mixed Methods Studies,' in Handbook of Mixed Methods in Social and Behavioural Research, A. Tashakkori & C. Teddlie, eds., SAGE Publications, London, pp. 321-351.

Schofield, J, 2000, 'Increasing the Generalizability of Qualitative Research', in Case Study Methods, R. Gomm, M. Hammersley, & P. Foster eds, SAGE Publications, London pp. 69-97.

Scriven, M. 1996, 'Types of evaluation and types of evaluator', Evaluation practice, vol. 17 no. 2, pp. 151-161.

Scriven, M. 200,. 'The logic of evaluation', in Dissensus and the Search for Common Ground, H.V. Hansen, et. al. eds, OSSA, Ontario, pp. 1-16.

Sinclair, A., & Dickenson, E. 1998, Effective practice in rehabilitation: the evidence of systematic reviews, King's Fund, London.

Shah, S., Vanclay, F., & Cooper, B. 1989, 'Improving the sensitivity of the Barthel Index for stroke rehabilitation', Journal of Clinical Epidemiology, vol. 42, no. 8, pp. 703-709.

Shih, F. 1998, 'Triangulation in nursing research: issues of conceptual clarity and purpose', Journal of Advanced Nursing, vol. 28, no. 3, pp. 631-641.

Shortell, S., Stephen, M., Gillies, R., Anderson, D. 1994, 'The new world of managed care: Creating organized delivery systems', Health Affairs, vol. 13, pp.46-64.

Silverman, D. 2005, Doing Qualitative Research: A practical handbook 2nd edn., SAGE Publications, London.

Schroeder, R. G., Van de Ven, A. H., Scudder, G. D., & Polley, D. 1989, 'The development of innovation ideas' in Research on the management of innovation: The Minnesota studies, A. H. Van de Ven, H. L. Angle, & M. S. Poole, eds., Harper & Row, New York, pp. 107-134.

Sheppard, S, & Iliffe S. 2005 Hospital at home versus inpatient care: Cochrane Review. Iss. 2, The Cochrane Library, Oxford.

Smith, P. 1992, The Emotional Labour of Nursing, Macmillan, London.

Smith, P. & Gray, B. 2001, 'Emotional labour of nursing revisited: Caring and Learning 2000', Nurse Education in Practice, vol. 1, no. 1, pp. 42–49.

Smith, P. & Gray, B. 2001a, 'Reassessing the concept of emotional labour in student nurse education: role of link lecturers and mentors in a time of change', Nurse Education Today, vol. 21, no. 3, pp. 230–237.

Smith, P. & Gray, B. 2009, 'Reassessing the concept of emotional labour in student nurse education: role of link lecturers and mentors in a time of change'. Nurse Education Today vol.21 no.3, pp. 230–237.

Solberg, B., Dirksen, C., Nieman, F., van Merode, G., Poeze, M., & Ramsay, G. 2008, 'Changes in hospital costs after introducing an intermediate care unit: a comparative observational study', Critical Care, vol. 12, no. 3, p.68.

Sosulski, M. & Lawrence, C. 2008, 'Mixing Methods for Full-Strength results', Journal of Mixed Methods Research, vol. 2, no. 2, pp. 121–148.

Spilsbury, K. & Meyer, J. 2001, ‘Defining the nursing contribution to patient outcome: lessons from a review of the literature examining nursing outcomes, skill mix and changing roles’, Journal of Clinical Nursing, vol. 10, no. 1, pp. 3-14.

Squires, A. J. & Hastings, M. B. 2002, Rehabilitation of the older person: a handbook for the interdisciplinary team, 3rd edn, Nelson Thornes Ltd, Cheltenham.

Stake, R. E. 1995, The art of case study research, SAGE Publications, Thousand Oaks.

Stake, R. E. 2000, ‘Case Studies,’ in Handbook of Qualitative Research. N. K. Denzin and Y. S. Lincoln, eds., SAGE Publications, Thousand Oaks, pp. 435-453.

Stake, R. E. 2006, Multiple case study analysis, SAGE Publications, London.

Steiner, A. 1997, Intermediate care: A conceptual framework and review of the literature, King's Fund, London.

Steiner, A. 2001, ‘Intermediate care: more than 'a nursing thing'‘, Age and Ageing, vol. 30, no. 6, pp. 433-435.

Steiner, A., Walsh, B., Pickering, R. M., Wiles, R., Ward, J., & Brooking, J. I. 2001, ‘Therapeutic nursing or unblocking beds? A randomised controlled trial of a post-acute intermediate care unit’, BMJ, vol. 322, pp. 453-460.

Steiner, A. 2002, ‘Intermediate care - a good thing?’, Age and Ageing, vol. 30-S3, pp. 33-39.

Stevenson, J. 2001, Mapping Local Rehabilitation and Intermediate Care Services: A whole system approach to understanding service capacity and planning change, King's Fund: London.

Stevenson, J., & Spencer, L. 2002, Developing Intermediate Care: A guide for Health and Social Services Professionals, King's Fund, London.

Strauss, A., Fagerhaugh, S., Suczek, B., & Wiener, C. 1982, 'Sentimental work in the technologized hospital', Sociology of Health & Illness, vol. 4, no. 3, pp. 254-278.

Tashakkori, A., & Teddlie, C. 2003, Handbook of Mixed Methods In Social and Behavioural Research, SAGE Publications, London

The British Red Cross, 2004, Proposed framework for self-evaluation by British Red Cross schemes supporting frail and vulnerable people at times of transition and change:

Intermediate care related services. A Balanced Scorecard, The British Red Cross, London.

Theodosius, C. 2008, Emotional Labour in Health Care: The Unmanaged Heart of Nursing, Routledge, New York.

Titchen, A. & Binnie, A. 1993, 'Research partnerships: Collaborative action research in nursing', Journal of Advanced Nursing, vol. 18, no. 6, pp. 858-865.

Townsend, J., Piper, M., Frank, A. O., Dyer, S., North, W. R. S., & Meade, T. W. 1988, 'Reduction In Hospital Readmission Stay Of Elderly Patients By A Community Based Hospital Discharge Scheme: A Randomised Controlled Trial', British Medical Journal, vol. 297, no. 6647, pp. 544-547.

Tuckman, B. 1965, ‘Developmental sequences in small groups’, Psychological bulletin, vol. 63, pp. 384–399.

Tuckman, B. & Jensen, M. A. 1977, ‘Stages of Small Group Development Revisited’, Group and Organization Studies, vol. 2, no. 4, pp. 419–429.

United Nations, 2007, Ageing 2007, United Nations Department of Economic and Social Affairs, Population Division/WPA2007.

United Nations, 2009, World Population Ageing 2009: Economics and Social Affairs, United Nations Department of Economic and Social Affairs/Population Division Department ESA/P/WP/212.

Van de Ven, A. & Kaambwa, B. 1981, Perspectives on Organization Design and Behaviour, A Wiley Interscience Publication, Toronto.

van der Putten, J. J. M. F., Hobart, J. C., Freeman, J. A., & Thompson, A. J. 1999, "Measuring change in disability after inpatient rehabilitation: comparison of the responsiveness of the Barthel Index and the Functional Independence Measure", Journal of Neurology, Neurosurgery, and Psychiatry, vol. 66, no. 4, pp. 480-484.

Van de Ven, A. 1986 Central problems in the management of innovation, Management Science, 32, 590-607.

Van de Ven, A., Polley, D., Garud, R., & Venkataraman, S. 1999, The Innovation Journey, Oxford University Press, Oxford.

Van Maanen, J. & Kunda, G. 1989, ‘Real Feelings: Emotional expression and organizational culture,’ in Research in organizational behavior, L. L. Cummings & B. M. Staw, eds., CT:JAI Press, Greenwich, pp. 43-103.

Vaughan, B. & Lathlean, J. 1999, Intermediate Care Models in Practice, King's Fund, London.

von Glasersfeld, E. 1995, Radical constructivism: A way of knowing and learning, The Falmer Press, London.

Wade, D., Severs, M., Dean, T., & Brooks, N. 2003, ‘Care-home versus hospital and own-home environments for rehabilitation of older people’, Cochrane Database Systematic Review no. 3(2).

Wade, D. T. & Collin, C. 1988, ‘The Barthel ADL Index: A standard measure of physical disability?’, Disability & Rehabilitation, vol. 10, no. 2, pp. 64-67.

Walsh, B., Steiner, A., Warr, J., Sheron, L., & Pickering, R. 2003, ‘Nurse-led inpatient care: opening the 'black-box'‘, International Journal of Nursing Studies, vol. 40, pp. 307-319.

Walsh, B., Steiner, A., Pickering, R. M., & Ward-Basu, J. 2005, ‘Economic evaluation of nurse led intermediate care versus standard care for post-acute medical patients: cost minimisation analysis of data from a randomised controlled trial’, BMJ, vol. 330, no. 7493, p. 699.

White, A. 2009, From Comfort Zone to Performance Management: Understanding Development and Performance, White & MacLean Publishing, Brussels.

Wiles, R., Postle, K., Steiner, A., & Walsh, B. 2001, ‘Nurse-led intermediate care: an opportunity to develop enhanced roles for nurses?’, Journal of Advanced Nursing, vol. 34, no. 6, pp. 813-821.

Wiles, R., Postle, K., Steiner, A., & Walsh, B. 2003, 'Nurse-led intermediate care: patients' perceptions', International Journal of Nursing Studies, vol. 40, pp. 61–71.

Wilson-Barnett, J., Griffiths, P., & Heard, S. 'Evaluating nurse-led inpatient units', Nursing Times, vol.15, no. 37, pp. 40–42.

Wilson, G., Hewitt, R., Ricahrds, S., & Shepperd, S. 2006, 'Development and testing of a questionnaire to measure patient satisfaction with intermediate care', Quality & Safety in Health Care, vol. 15. pp. 314–319.

Wilson, A. & Parker, H. 2003, 'Intermediate care and general practitioners: an uncertain relationship', Health & Social Care in the Community, vol. 11, no. 2, pp. 81–84.

Wilson, K., Clegg, A., & Fairclough, F. 2005, 'Implementing the single assessment for older people', Nursing Times, vol. 101, no. 43, pp. 32–35.

Yohannes A, Baldwin R, & Connolly M. 2008 Prevalence of depression and anxiety symptoms in elderly patients admitted in post-acute intermediate care. International Journal of Geriatric Psychiatry, vol. 23, pp.1141-7.

Yin, R. K. 1994, Case Study Research Design and Methods, 2 edn, SAGE Publications, London.

Yin, R. K. 2003, Case Study Research: Design and Methods, 3rd. edn, SAGE Publications, Thousand Oaks.

Yin, R. K. 2003a, Applications of case study research, 2nd edn, Sage Publications, Thousand Oaks.

Young, J., Robinson, M., Chell, S., Sanderson, D., Chaplin, S., Burns, E., & Fear, J. 2005, 'A prospective baseline study of frail older people before the introduction of an intermediate care service', Health & Social Care in the Community, vol. 13, no. 4, pp. 307–312.

Young, J. B., Robinson, M., Chell, S., Sanderson, D., Chaplin, S., Burns, E., & Fear, J. 2005, 'A whole system study of intermediate care services for older people', Age and Ageing, vol. 34, no. 6, pp. 577–583.

Young, J. and Stevenson, J. 2006. 'Intermediate Care in England: Where Next?' Age and Ageing, vol. 35, pp. 339-341.

Young, J., Green, J., Forster, A., Small, N., Lowson, K., Bogle, S., George, J., Heseltine, D., Jayasuriya, T., & Rowe, J. 2007, 'Postacute Care for Older People in Community Hospitals: A Multicenter Randomized, Controlled Trial', Journal of the American Geriatrics Society, vol. 55, no. 12, pp. 1995–2002.

Young, J. 2009, 'The development of intermediate care services in England', Archives of Gerontology and Geriatrics, vol. 49, no. Supplement 2, p. S21–S25.

Zimmerman, J. E., Wagner, D. P., Knaus, W. A., Williams, J. F., Kolakowski, D., & Drapper, E. A. 1995, 'The use of risk predictions to identify candidates for intermediate care units: implications for intensive care utilization and cost', Chest, vol. 108, pp. 490–499.