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UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

Centre for Innovation and Leadership in Health Sciences

**Discharge decision-making for older people on an Acute Medical Unit. An
ethnographic study.**

by

Annabel Mary Rule

Thesis for the degree of Doctorate of Philosophy

April 2018

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF HEALTH SCIENCES

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DISCHARGE DECISION-MAKING FOR OLDER PEOPLE IN AN ACUTE MEDICAL UNIT. AN ETHNOGRAPHIC STUDY

By Annabel Mary Rule

Health care policy consistently reflects the need for increased involvement of patients and relatives, or a shared decision-making approach in the care decisions of older people. It has been proposed that these approaches will improve patient experience and efficiency in acute care and discharge planning for older people. Despite this, poor discharge experiences for older people with a lack of involvement are consistently reported and receive much public, clinical and academic attention. This doctoral project synthesises policy and research to date and aims to explore and understand the processes by which discharge decisions are made for older people returning to the community from an acute medical unit in the English NHS.

An ethnographic approach was used across two research phases. The first phase focussed on older patients' experiences of discharge decision-making. The second phase focussed on the practice of discharge decision-making. Methods used included observation (~54 hours in the field plus 17 nursing handovers), interviews with patients (N=12) and relatives (N=9), two group interviews with professionals (N=7) and the collection of documentary evidence (N=10). Data were analysed using the constant comparative method.

Findings indicated that there was no conceptual space for shared decision-making to occur on the unit and that care was punctuated by an ingrained pace focus. Health professionals prepared for the battle of discharge decision-making, patients felt guilt and illegitimacy and relatives were put upon to support discharge.

It was concluded that the AMU had a rigid temporal structure that lacked flexibility for shared decision-making to take place and for the complex needs of older people to be fully acknowledged. This structure was continually reinforced by targets and policy. For improvements in the uptake of patient-centred care initiatives, such as shared decision-making, and for improved experiences of discharge decision-making, existing policy needs to be reconsidered.

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DECLARATION OF AUTHORSHIP

I, Annabel Rule, declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Discharge decision-making for older people on an Acute Medical Unit. An Ethnographic Study.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. 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;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. 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;
5. I have acknowledged all main sources of help;
6. 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;
7. Some of this work has been published as part of dissemination activities. Please see Appendix A for a full list.

Signed:

Date:

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Definitions and Abbreviations

ADL – Activities of Daily Living

AMU – Acute Medical Unit

BGS - British Geriatrics Society

BMJ – British Medical Journal

CGA – Comprehensive Geriatric Assessment

CQC – Care Quality Commission

ED – Emergency Department

KPIs – Key Performance Indicators – on which the success of a team or service is measurable

MDT – Multidisciplinary team

MPs – Members of Parliament

NAO – National Audit Office

NHS – National Health Services

NICE – National Institute for Health and Care Excellence

NSF – National Service Framework

RCT – Randomised Controlled Trial

SCIE – Social Care Institute for Excellence

Chapter 1: Introduction

1.1 Rationale for this study

The number of older people (aged 65 and over) in England is increasing rapidly, and by around a fifth every ten years. Emergency admissions for older people have gone up at an even faster rate by 18% from 2010-11 and 2014-15 (House of Commons Committee for Public Accounts 2016). Despite this, acute hospital beds have reduced in numbers by 43% since the late 1980s (Ewbank et al. 2017). Acute Medical Units (AMUs), or similar short stay units, in the English National Health Service (NHS) are being increasingly used to manage older people with acute medical needs as a bridge between the ED and the specialist medical wards (Conroy & Cooper 2010). This increasing use of short stay units is indicative of the push from a governmental level for older people to be discharged home within a short length of time as well as assist in the reduction of acute hospital bed capacity (N.H.S. England 2013). It has been consistently reported that older people in the English NHS experience poor quality of care at discharge (Parliamentary and Health Service Ombudsman 2016). Since the National Service Framework (NSF) for older people was published in 2001 in a bid to eradicate ingrained ageism in the health service, patient involvement and shared decision-making has consistently been called for to improve experiences of care and discharge (Department of Health 2001). Despite this, research on acute care experiences for older people has continued to report missed opportunities by health care professionals to share decisions about care and treatment with older people (Bridges et al. 2010). Research on discharge planning also shows a lack of patient involvement in the discharge planning process, but there appears to be a lack of studies investigating the discharge decision-making process specifically in a way that captures clinical practice and the influences on it (Ekdahl et al. 2012; Dyrstad et al. 2015). Given the rise in AMU use, this study aims to describe and explain the processes by which discharge decisions are made for older people returning to their home from an AMU. This study has sought to understand if the policy and expectations of discharge decision-making are reflected in practice and if not, why this may be and what happens instead. The objectives of the study are as follows;

1. To understand the context within which discharge decisions are made
2. To explore the impact of the context of the AMU on those involved in discharge decision-making (patients, staff and relatives).
3. To explore the impact of the AMU context on discharge decision-making and identify the characteristics of the process of discharge decision-making in this context
4. To describe the impact of discharge decision-making practices on all those involved in the process (patients, staff and relatives).

1.2 Guide to the thesis

This study took an ethnographic approach to meet the aims and objectives. It sought the perspectives of patients, relatives and health professionals through interviews, observations, group interviews and the collection of documentary evidence. The study took place across two phases; one focussed on the patient experience and the second focussed on the practice of discharge decision-making.

The second chapter of this thesis provides a background and introduction to some of the evidence base and theories regarding older people in society, in the NHS and in acute care. It introduces concepts relevant to how older people receive care and their role in decision-making such as independence, dependence and autonomy. Further detail regarding AMUs and their role in older people's acute care is also provided.

Chapter three introduces the concepts of involvement and shared decision-making and analyses their place in government thinking and NHS organisations. It provides a timeline of the policy surrounding the call for increased efforts to involve people in their care. The chapter then evolves to discuss the concept of shared decision-making and how this and similar concepts are recommended in current practice for older people in environments such as the AMU.

Chapter four provides a comprehensive summary of the current literature relevant to this study. Firstly, it provides a critical overview of the discharge planning literature which was a starting point for the development of this study. Then, the literature specific to discharge decision-making in acute care is synthesised and the lessons learnt from the existing literature are described in how they shaped the approach to this current study.

Chapter five provides explicit detail and explanation for the methodological choices made in this study and the exact methods that were undertaken. This chapter is reflexive in nature and therefore provides an in-depth understanding of the conditions and situations that enabled this study to take place.

In chapters six and seven, the findings of the study are detailed. First, chapter six provides the findings relating to the first and second objectives regarding the AMU context and the impacts of the context on the experience and behaviours of all those involved; patients, health professionals and relatives. Chapter seven details the findings relating to the third and fourth objectives and describes how discharge decisions are made on the AMU and the impact of the process on those involved.

Chapter eight discusses these findings in relation to the theories and analysis undertaken in chapters two and three. The unique contributions of this study are then explored and used to confirm or broaden existing theories of acute care and discharge decision-making for older people. This chapter concludes with seven recommendations of further research and work required with regard to policy, education, clinical practice and research.

Appendices are referred to throughout and can be found at the end of this thesis. The dissemination activities that have been undertaken throughout this project and studentship are detailed in Appendix A including presentations and published work. Throughout the thesis the writing style occasionally changes to a more reflective first person account indicated by the use of italics. Abbreviations in this thesis have been kept to a minimum where possible. In instances where abbreviations are used a full explanation of the abbreviation is provided on first use and then the abbreviation used for the remainder of the thesis. Abbreviations are also listed on page xv.

Chapter 2: Older people, dependency and autonomy in healthcare

2.1 Introduction

This chapter provides a background to the existing thinking and evidence regarding older people's care in acute hospitals. It begins by introducing how older people are viewed in society and healthcare with regard to their autonomy and identity. Current research and theories on the impact of the acute hospital experience on older people's autonomy and identity are also discussed. As the thesis progresses these concepts will be revisited to aid interpretation and ensure findings are orientated to existing knowledge and theories. Finally, acute care and AMUs for older people are introduced.

2.2 Older People in Society

“ The self is not monolith; it is plastic, variable and complex” (Cohen 1994 p.2)

The National Service Framework (NSF) for older people set out eight standards to be achieved over ten years in a bid to eradicate issues relating to ageism and a lack of dignity for older people that had been identified as inherent in the healthcare system (Department of Health 2001; Filinson 2008). The language used in these standards showed an acknowledgement of older people as individuals capable of making decisions autonomously and of persons who are able to contribute to planning their care. This language is indicative of the direction of progression of social reforms at the time, particularly in terms of increasing consumer sovereignty and holding health and social care to accountable standards (Filinson 2008). Despite these positives, the NSF's focus on independence and autonomy can be seen as exacerbating the negative perceptions on the loss of independence and autonomy in Western Society and may not be truly representative of older people's experiences (Lloyd et al. 2014).

Agency, the ability to be self-directed, cannot be uncoupled from a person's individual identity (Cohen 1994). For the purpose of this discussion, it is understood that although some authors may debate the subtle differences between individual, person and self, as Cohen (1994) argues, the differentiation between them is arbitrary. This is particularly true within the healthcare context where terms such as 'person-centred' and 'individualised care' are used concurrently.

Chapter 2

Old age as a definition has been much debated. It has been widely agreed that a number indicating that one is now old is not sufficient (Pickard 2016). Instead, old age is often discussed as the 'third' and 'fourth' age (Laslett 1991). Laslett (1991) describes the first age as a period of dependence, socialisation, immaturity and education. The second of independence, maturity and responsibility, the third age as an era of personal fulfilment and the fourth as a final stage of dependence and decrepitude that culminates in death. In recent years, the transition from third to fourth age has been diagnostically defined by the introduction of 'frailty' as a syndrome that someone has and can prevent (Pickard 2016). Psychologically, the transition to the fourth age can mean a diminishment of qualities such as mastery, autonomy and cognitive potential (Baltes & Smith 2003).

The way 'older people' as a category of society are portrayed in the everyday continually produces and reproduces their identity (Latimer 1997). From their absence in TV and film to the road sign that shows a man bent double over a walking stick as a warning that there may be older pedestrians nearby, the negative perception of 'older people' is reinforced (Latimer 1997; Pickard 2016). If older people do feature in advertisements and media, they are wealthy, glamorous and intelligent and have the means to maintain this (Pickard 2016). Those people have successfully aged. This means they have managed to age so that they are devoid of deficits, productive and socially engaged (Pickard 2016)¹. Those who have not aged successfully, become 'the elderly' or 'older people' in a stigmatised identity (Cohen 1994). In everyday life, this consigned category of an 'older' or 'elderly' person in the fourth age, equates older people as incompetent beings that do not contribute to society and instead are a drain on resources and productivity (Cohen 1994; Pickard 2016). The focus on the syndrome of 'frailty' has made way for the prevailing trope that one can prevent frailty or slow its decline², implying that ageing successfully is a choice (Pickard 2016).

Previous work has reported the experience of older people having their sense of self de-graded, as the public discourse enables them to feel as though they no longer serve society in any positive way (Cohen 1994). Even if they 'age successfully' the moment this productivity and social engagement is stopped, the negative consignment of the older identity is once again devalued and feared by those aging (Pickard 2016). Thus, in their everyday, older people have to go to great effort to reassert their sense of self, override the social subversion and maintain themselves (Cohen 1994; Lloyd et al. 2014). This need is strongly associated with the public discourse on

¹ Examples in the UK context would be Mary Berry, Dame Vivienne Westwood or Michael Caine

² For example, by eating healthily, maintaining an active social life and participating in exercise programmes

dependence and independence and needs to be considered as health care policy, older people's experiences and health care decision-making is explored in this thesis.

2.2.1 Ideal of independence and 'older people'

The daily internal battle to override social subversion is made worse when entering an organisation such as a hospital. The risk in hospital is that the self can be neutralised and diminished if one has been consigned to a category, for example, as someone who has social needs only or as a person who is difficult (Cohen 1994). The categorisation of a person having only 'social' needs in hospital is a risk for people with frailty who may require new support due to a decline in their abilities to manage (Pickard 2016). Inherent within the notion of requiring care is the dichotomy of being dependent or independent. The ideal of independence has infiltrated all levels of modern society, especially in the commentary related to health and social care (Weicht 2010). Holding independence as an ideal is a contradiction in care. For care to occur somebody needs to be dependent on somebody else. Therefore, for those within the fourth age or perceived as having frailty, older people are seen in society as the opposite of the ideal; passive, dependent, non-actors whose life is determined by others (Weicht 2010; Pickard 2016). Weicht (2010), following critical analysis of the discourse on care for older people in the UK and Australia, acknowledges that this dichotomy may not be reflected in individuals' subjective experience but found it to be deeply embedded in public discourse on care. In addition to the way dependence and independence is constructed, the young body versus the old body also portrays the older person as not able to contribute to their own life or society. Those older people who have not aged "successfully" are depicted as a societal burden instead (Pickard 2016). The young body is associated with activity whereas the older body, let alone the ill body, is associated with the body failing to do what it needs to do, that the previous younger body is no longer there and therefore the former self is gone (Weicht 2010).

This ingrained othering of both the old and of recipients of care explains the tendency for people who qualify as older people to distance themselves from the identity of 'old'. This phenomenon was explored in a UK interview study (Jones 2006). Using positioning theory, it was concluded that older people position themselves as 'older' rather than 'old' because this is not an absolute categorisation. Also, they often disassociate themselves from the category when discussing something about themselves that doesn't fit within the 'older person' stereotype, for example, they may refer to themselves as 'different', 'special' or 'still young at heart' (Jones 2006). Rather than qualifying older people as 'incorrect' and 'incompetent' for not choosing to refer to themselves as 'old' or 'elderly', this study shows how older people purposefully use a flexible discourse to categorise and position themselves (Jones 2006). This also leads to older people

Chapter 2

discussing becoming old as being fearful of becoming a 'burden' or becoming dependent and wanting to avoid it altogether (Weicht 2010). This act of othering being 'older' helps older people maintain their own, individual identity but also reflects the 'othering' and marginalisation of 'older people', particularly those considered in the fourth age, by society at large (Weicht 2010; Pickard 2016).

The concern is that concepts such as involvement and shared decision-making that are born out of a need to overturn the way that 'older people' are constructed in society and healthcare, actually serve to continue the demonization of dependency (Weicht 2010). This tension is at its most taut in the hospital environment where patients are the epitome of dependent individuals.

Public discourse regarding older people and dependency is such that older people work constantly to either distance themselves or better fit in with processes to ensure they are not absolutely consigned to a category such as 'socially dependent older person'. This idea of older people adapting, using flexible discourse and 'lying low'³ to compensate is evident in studies by both Latimer (1999) and Jones (2006). Although this can be argued to be evidence of older people as actively orchestrating their identity, the impact of how society and themselves' construct their identity, their autonomy and their right to contribute to a decision is unclear.

2.2.2 Types of autonomy

The idea of autonomy is much debated in the field of political and medical ethics. As this thesis is focussed on decision-making, it is important for the concept of autonomy to be introduced as without autonomy there would be no decision-making. Literally, autonomy means self-determination and self-governance (Stirrat & Gill 2005). In philosophy the most prominent interpretation is that of Kantian autonomy, in which moral obligations and will are determinants within societies, colonies and states (O'Neill 2003). There are other interpretations and uses of autonomy, some that use autonomy as a synonym of independence and 'rational autonomy' where choice is morally rationalised but neither are necessarily reflective of Kant's original interpretation (O'Neill 2003). To help in understanding what makes a Kantian autonomous decision is to understand what is meant by the opposite of autonomy, heteronomy (O'Neill 2003). A heteronomous decision is one for which the reasoning can be attributed to an overriding authority, like a religion, a ruler, the majority or just initial inclination (O'Neill 2003). In that sense, the decision hasn't been reasoned as it's been made arbitrary due to the overriding authority, be

³ More on Latimer's (1999) concept of 'lying low' in hospital in section 2.3.1

it a dogma or a desire (O'Neill 2003). An autonomous decision is the opposite, not led by an ascribed authority and rationalised with moral obligation and will.

The version of autonomy which is now a well-established feature of western society, particularly in English speaking countries, is 'individualistic autonomy' (Stirrat & Gill 2005). This version of autonomy relates to a person's right to act according to their own interests and morals that are unique to them without influence from anyone else. This modern translation of autonomy, fitting with the aforementioned independence ideal, is heavily criticised particularly in the context of medical ethics. Stirrat and Gill (2005) describe individualistic autonomy as fundamentally flawed and that medical ethics should always be orientated within a background of relationships and community. In contrast they propose a 'principled autonomy' where patients are provided with sufficient and understandable information and space to make informed and reasoned judgement on care with responsibility for the impact of that on others (Stirrat & Gill 2005).

Going further than 'principled autonomy', 'relational autonomy' is grounded on feminist theory and recognises that more than rational deliberators, actors are social beings whose identities are shaped by a complex web of social relations (Sherwin & Winsby 2011). It also positions autonomy as a competency, where the necessary skills to execute autonomy can be developed (Sherwin & Winsby 2011). Relational autonomy seeks to undo the diminished sense of self and self-trust that older people may feel as part of a social group attached to much negative bias (Sherwin & Winsby 2011). In response to the dependence and independence dichotomy, relational theory makes explicit that most social beings operate with layers of interdependence within our webs of social relations (Sherwin & Winsby 2011). Returning to identity, relational interpretations of autonomy also acknowledge the fluctuating identity in the fourth age as changes to pre-existing relationships (i.e. the loss of loved ones) are replaced with relationships with carers and health professionals that still allow for the social construction of ones' identity (Lloyd et al. 2014).

Therefore, these forms of relations should be considered as the relational contexts for which any decision is made, especially as they may change in the fourth age (Gibson 2015). For decisions such as discharge which impacts the individual, the individual's network of social relations and is informed by health professionals, a relational perspective on autonomy seems most appropriate. However, conflict arises as the 'individualised autonomy' perspective has infiltrated much of the ideals of Western culture and therefore permeates much of health care policy and public rhetoric with regard to older people and dependency. Although the policy message to share healthcare decision-making and promote involvement does not completely adopt this individualised autonomy (further exploration of policy can be found in chapter threeChapter 3:), it does reflect the values of society at large. The reciprocity of shared decision-making reflects more closely the

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'principled autonomy' as described by Stirrat and Gill (2005) but still doesn't accept the relational interdependency to the extent of relational autonomy. It will be necessary to understand these three interpretations of autonomy as discharge decision-making is focussed upon in this thesis.

This section has focussed on some of the sociological components that shape the way healthcare and decision-making is experienced for older people. How patients behave and operate as social actors in discharge decision-making is not only shaped by their individual sense of self, it is also shaped by the societal categorisation that they fall into, how the environment and organisation of the hospital serves to categorise them and the way in which their autonomy is considered, shaped or encouraged within this.

2.3 Acute care for older people

This section focusses on some key texts that explore older people's care in acute hospitals. It provides an introduction to frame a review of more focussed literature in chapter four. Much of the literature on older people's experiences in acute health care focus on the principles discussed in the previous section; identity, autonomy, older people contorting to fit with the healthcare they receive and a relational approach to care.

2.3.1 Acute care for older people misses relational connection

A qualitative synthesis that aimed to review the experiences of older people and their relatives of acute care sought to underpin the revision of national nursing guidance that was initially published in 2001 alongside the NSF for older people (Bridges et al. 2010). The synthesis used a systematic approach to searching, study selection, data extraction and a comparative thematic analysis approach (Bridges et al. 2010). Studies that sought the experiences of older people specifically were sought and therefore no comparison to other patient groups were achieved. Some of the findings could be comparable across all those who experience acute care.

The review identified that acute care for older people was an experience of fear, worthlessness and a lack of autonomy (Bridges et al. 2010). The 'relational aspects of care' were the focus of older people and their relatives' experiences over the technical aspects of care (Bridges et al. 2010). Consistently within the review three features of relational care were associated with the positive experiences of acute care; connection, identity and shared decision-making (Bridges et al. 2010). A feeling of 'connection' and a reciprocal relationship with hospital staff was identified to ensure that patients felt significant as an individual who matters, legitimate as a patient and reassured that they would receive the treatment and care that would meet their needs (Bridges et al. 2010). It was also acknowledged that maintaining connections with their pre-existing social

networks also helped patients to feel supported (Bridges et al. 2010). This personal connection was fostered by staff interventions that made patients and relatives feel cared for, respected and welcome (Bridges et al. 2010).

Sharing decision-making was also a recognised aspect of care that promoted positive experiences. Poor levels of participation in decision-making tended to be associated with social standing, level of education and feelings of dependency on others – echoed by the findings of an earlier narrative synthesis of older people’s experiences of hospital discharge (Fisher et al. 2006). Bridges et al. (2010) acknowledge that preferences or abilities to be involved in sharing decisions may vary between individuals but that ensuring some level of involvement would serve to lessen patient and relatives’ anxiety. This review is comprehensive in tackling older people and relatives’ experiences of hospital care, but acknowledges the “missing piece” of the hospital staff perspectives to understand that experience as a whole (Bridges et al. 2010).

From a sociological perspective the phenomenon of older people in hospital was explored in great depth in an ethnographic study of an NHS acute medical unit over an 8 month period, one of the 48 papers included in Bridges et al. (2010)’s review (Latimer 1999). The study aimed to examine the ways that older people are treated in the hospital environment and address how everyday care practices reflect wider social trends (Latimer 1999).

Latimer (1999) focussed specifically on the effect of the hospital processes on older people’s individual identity. Similarly to Cohen (1994)’s findings, she notes that patients’ social and personal identities are ‘cleared away’ as they transition from person who enters a hospital to admitted patient (Latimer 1999). From this point, patients are configured as ‘medical objects’ and allocated to relevant medical categories. Some categories allow professionals to suspend responsibility for their care (e.g. the categorisation of a ‘long term geriatric patient’ leads that patient to be admitted to a rehabilitation setting) and some categories are loaded with negative connotations (e.g. the ‘polluting category’ of those whose needs are primarily ‘social’ and not ‘medical’ and are therefore a drag on the flow of the unit) (Latimer 1999). This categorisation is implicit in the de-personalisation that makes the relational aspects of care so important to older people and their relatives (Bridges et al. 2010).

Throughout their hospital stay, older people continue to be re-assessed, re-configured and re-categorised. At points, this re-categorisation required negotiation amongst professionals in MDT meetings using information from the professionals’ observations of patient conduct and never in a context accessible to older people (Latimer 1999). This makes clear why sharing decisions was also of importance in older people and their relatives’ experiences (Bridges et al. 2010). It is the categorisation of patients that is needed to progress and move them through the system.

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Although this description of hospital process for older people sounds indicative of a process lacking in older people's involvement, Latimer (1999) argues that patients are active participants within it.

Patients are aware that their conduct and behaviour is the main evidence on which professionals base their category negotiations. They trust that their concerns will be listened to regardless of whether they are affirmed at the time they are voiced, they learn that there is an order of normal practice, try to adhere to it where possible and learn not to insist (Latimer 1999). Those who are deemed to be 'borderline, psychosomatically ill or merely old' can be categorised as 'social' if they do not respond and adapt to the normal order of practice as other patients. To counteract this, many have to efface their concerns, particularly if they are social, in order to avoid being categorised in that way (Latimer 1999). Latimer (1999) terms this act of fitting in and effacement as 'lying low' and theorises the reasons why this behaviour occurs. Firstly, 'lying low' is encouraged by the interactions with health professionals, particularly with nurses. Latimer (1999) observed the continual deferral and displacement of patients by nurses as they prioritised their nursing agendas, assessments, observations and lists. A recent mixed methods study focussing on nurses' experience of acute care concluded that the demanding, time-pressured, unsatisfactory nature of the nursing role in this context with unpredictable staffing levels and complexity of patients meant that nurses were not able to provide the same level of care to all patients (Maben et al. 2012). Instead they subconsciously categorised patients to "poppets, parcels and demanding patients" (Maben et al. 2012). Parcels were processed through the care pathway with no 'extra' or 'relational' care provided, demanding patients were seen by the nurses to be those for whom no amount of care was enough and poppets were selected patients who had the sympathy of the staff and to whom they dedicated their energy and time to in order to regain some job satisfaction (Maben et al. 2012).

Patients who are motivated to remain independent work hard to ensure that they are not consigned to categories synonymous with dependence and instead perform, lie low and fit in so that health professionals can justify that the patients have acute medical needs (Latimer 1999; Bridges et al. 2010). Latimer (1999 p.205) describes the older people that 'lie low' as "*being responsible, engaged, concerned, compliant, reasonable, resigned, uncomplaining, to assist in the assignment of their identities to the appropriate clinical categories.*" They are actively self-effacing. Given the understanding from the nurses experiences in Maben et al. (2012)'s study, it is likely that those who 'lie low' are more likely to be treated like a 'poppet' and not receive 'parcel' or worse, 'demanding patient' level of care.

Approaches such as ethnography (Latimer 1999) and mixed methods (Maben et al. 2012) help to understand issues related to policy and practice in their naturalistic context and explore how policy agendas are a product of social trends. As Latimer's (1999) fieldwork took place in the mid-late 90s it provides an interesting comparison point for more current research to explore if developments have been made as the policy message and potentially the social trends have progressed. It adds an interesting perspective to the way in which involvement and participation is considered in aspects of care such as decision-making. What may not look like active involvement could still be an active participation. Behaviour that may not seem to reflect the identity and autonomy of an older person may be intentional to better fit within the system that they find themselves in to ensure their care is such that preserves their independence and their ability to participate in society even if in a diminished way. The way we typify what involvement looks like (behaviours such as asking questions, voicing opinions, disagreeing and debating) may need to be reconsidered as Latimer (1999) highlights that this may not be a realistic representation of participation within the acute hospital environment. This is significant considering the impact that the working conditions and environment have on the way nurses prioritise the care they give (Maben et al. 2012). Only the select few receive the person-centred relational care that Bridges et al. (2010) concluded mattered most to older people .

2.3.2 Delivering acute care for older people in the “perform or perish” context

Culture change within healthcare services and organisations, particularly the English NHS, is often cited as the only way to improve acute care for older people (Patterson et al. 2011). Built on this acknowledgement, Patterson et al. (2011) aimed to understand the concept of quality of acute care for older people as well as explore applied cultural change and potential performance outcomes. This study took a multi-case comparative case study methodology to allow for comparisons across hospitals and individual wards who were implementing change initiatives in older people's care (Patterson et al. 2011). As part of this work, in-depth interviews were completed with staff members on each unit in senior positions (Patterson et al. 2011). One of the theoretical lenses that Patterson et al. (2011) used to interpret their findings was the Senses Framework (Nolan et al. 2006). Proposed as a potential framework to underpin nursing practice, the Senses Framework identifies that all participants in care should experience a sense of; security, belonging, continuity, purpose, achievement and significance (Nolan et al. 2006). It is argued that when all of these senses are experienced by both patients and staff members it constitutes an 'enriched environment' which should result in positive experience and provide a sound foundation for culture change and innovation. The findings of Maben et al. (2012) were also discussed in relation to the Senses Framework where it was established that nurses could not

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facilitate their patients to experience the senses as they themselves did not feel secure, belonging, continuity, purpose, achievement or significance in their place of work. Using this theory as an interpretive lens allowed Patterson et al. (2011) to explore if these senses were evident in contexts where cultural change was happening successfully.

Another theory that underpinned Patterson et al.'s (2011) inquiry was the theory of a 'Pace-Complexity' dynamic (Williams et al. 2009). This theory was founded on the results of a study using interviews and a grounded theory approach to gain the perceptions of all stakeholders and empowered them to gain consensus on the issue of and solutions for discharge planning in a Welsh NHS hospital. The theory describes how if pace is the focus of care, patients are pushed out, not involved and receive input focussed solely on medical issues (Williams et al. 2009). This is congruous with Maben et al.'s (2012) 'parcels'. If complexity is the focus, more brokering, negotiating and advocating behaviours are experienced with a higher focus on the relational aspects of care (Williams et al. 2009).

Despite some difficulties in gaining qualitative data from patients and carers due to ethical considerations and the acuity of the patients involved, Patterson et al. (2011) were able to gain valuable insights into the challenges for culture change in acute NHS settings. In particular, and echoing Williams et al.'s (2009) theory, concerns were raised regarding the focus on pace of delivery in acute care for older people, the NHS in general and with regard to change initiatives. A lack of consideration for the complexity of the issues involved and processes needed for real and enduring change to occur is also argued to be reinforced by the use of targets and a transactional approach to change (Patterson et al. 2011).

Patterson et al. (2011) describes this as a "perform or perish" model of service delivery as success is attributed only to the achievement of punitive targets that are pace focussed. These targets are representative of a quantitative philosophy on time that reinforces utilitarian-economic approach to service delivery and are communicated within UK governmental healthcare policy (Zerubavel 1981; Patterson et al. 2011). Within a "perform or perish" model, there is a top-down agenda to the organisation with transactional leadership where success is measured by quantitative metrics and the care provided is process driven (Patterson et al. 2011). Additionally, when healthcare is overcome with recommendations and new initiatives they have to be prioritised, which Patterson et al. (2011) argue is reason for why improvements following the NSF for older people were limited (Department of Health 2001). Finally, referencing work by Bridges et al. (2010) and acknowledging the issues of changing culture, Patterson et al. (2011) adds to the discussion that adopting a relational approach to care could bring the focus away from pace and back to complexity and the individual.

The key works described in this section explore the acute care experience for both older people and health professionals and provide some of the theory that will assist in the interpretation of the findings within this thesis. All of these works have focussed on the care of older people as an exemplar of issues that may also exist in other clinical specialities but for those in the fourth age can be the most problematic. Particularly, Latimer's (1999) actively self-effacing older person in discharge decision-making and Maben et al.'s (2012) nurse categorisation of older people as 'poppets, parcels and problems' will underpin the interpretation of findings from this study. Additionally the extent to which Nolan et al.'s (2006) Senses Framework, Williams et al.'s (2009) pace-complexity dynamic and the relational approach to care as discussed by Bridges et al. (2010) and Patterson et al. (2011) are evident or applicable to this study's findings will be discussed.

2.4 Acute medical units for older people

This section introduces the AMU in the English NHS and the issues and factors that impact on older people's care that are specific to these kinds of clinical environments as well as why it is crucial to focus on these environments when considering discharge decision-making.

The literature specifically focussed on older people's care within AMUs was limited when this doctoral project first began. To some extent this may be due to the variability of AMUs in the English NHS and internationally, with many having different abbreviations and local names as well as different systems, remits and processes. In this thesis the term AMU is understood to mean a short stay unit that provides care to all patients with acute medical needs. Acute admissions in the English NHS have been growing exponentially and older people are the fastest growing group of patients presenting to AMUs (Conroy & Cooper 2010).

Policy regarding acute hospitals has tended to focus upon ensuring lengths of stays are shorter, readmissions are reduced and the throughput of patients through the hospital is quick. As a result of this focus, the need to readdress urgent care pathways and increase efficiency has been a main aim (N.H.S. England 2013). Implementation and growth of short stay units in acute NHS hospitals has been in alignment with this focus. These units aim to bridge a gap between the emergency department and the inpatient wards and are places where patients can be assessed, triaged, treated, transferred or discharged as is appropriate to their needs (Bell et al. 2008). Short stay units, such as AMUs, are now found in around 90% of UK hospitals (Scott et al. 2009).

A systematic review that looked at studies based on sites in England, Scotland and Ireland concluded that AMUs help to reduce length of stay and access to the emergency department without having a detrimental effect on readmission rates or patient and staff satisfaction (Scott et al. 2009). This review was based on a limited number of studies, all of which were detailing the

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effect of a reorganisation of hospital care by implementing an AMU. No randomised controlled trials (RCTs) were found and therefore Scott et al. (2009) argue that the benefits reported are not conclusive and further evidence is required. Furthermore, trials investigating the outcomes specific to older people or older people with frailty would be most useful as they are the largest growing population attending AMU facilities (Conroy & Cooper 2010).

Despite the potential benefits, the nature of a short stay implies that time to develop relationships with older people and prepare for discharge is limited. With this comes some speculation that discharge readiness and re-admission rates could be affected. In a single centre questionnaire study in Australia, 89% of patient participants reported feeling satisfied with their discharge from a short stay unit plus 85% reported that they received adequate discharge information and advice (Arendts et al. 2006). Despite this, 29% of this cohort reported having had an unscheduled visit to a health professional for the same medical problem or symptom up to eight weeks after discharge (Arendts et al. 2006). The patients in Arendts et al's (2006) study had a median age of 64 and therefore are unlikely to represent the needs and experiences of older people, in the fourth age.

Similarly, in another Australian single centre audit, it was found that there is a significant difference in failure rates of discharges from a short stay unit for those over 70 years old when compared to those under the age of 70 ($P < 0.01$) (Shetty et al. 2015). What is considered a failed discharge can be contested depending on the organisation and the individual patients. This study determined a failure in discharge from a short stay unit to be one where the discharge did not occur within 24 hours. This is a particularly tight timeframe and therefore presents data framed around a target driven environment rather than attributing a failed discharge as one of poor quality or poor experience (Shetty et al. 2015)⁴. Additionally, it has been found that older people who stay in hospital for less than 72 hours are likely to be readmitted significantly earlier than patients who stayed in hospital for longer than four days (Dobrzanska & Newell 2006). All of these reports are not conclusive and largely based in single centres so the results cannot be assumed to be applicable to all AMUs. Plus, many of the studies focus on general population rather than specifically older people.

It seems that there is no clear evidence about the process of discharge of older people from these units with a lack of RCTs, largely single centre studies and audits which primarily describe a re-organisation of acute services (Scott et al. 2009). RCTs would help clarify any potential cause-

⁴ It is widely argued that the term "failed discharge" is redundant as often the nature of being an older person with co-morbidities and/or frailty means that needs may change with the passing of time and therefore discharge plans are trialled and amended if needed rather than "failed".

effect relationship that may exist but would be very difficult to complete in the NHS where 90% of hospitals already have AMUs (Sibbald & Roland 1998; Scott et al. 2009). With enough description of the services under exploration in these small studies, those that work in AMUs may be able to establish how comparable the findings may be to their own units (Bellomo et al. 2009).

Additionally, reports tend to explore readmission rates and length of stay but the impact on individuals' experiences and interpretations of quality care that are not organisational or target driven have not been a priority (Arendts et al. 2006; Dobrzanska & Newell 2006; Shetty et al. 2015).

Despite this, researchers have aimed to establish the reasons why readmissions may be more frequent or likely following discharge from short stay units. Some argue that the health trajectory and nature of older people's long term conditions mean that readmissions are inevitable to some extent (Slatyer et al. 2013). This is specific to people who present with exacerbations of their cardiovascular or pulmonary conditions, mobility issues and histories of falls. Additionally, the environment of an AMU has implications for communication. The busyness, pressure and stressfulness of the environment impacts upon relatives' and patients' understanding of discharge, their condition and medication information (Slatyer et al. 2013).

For older people, the British Geriatrics Society (BGS) considers AMUs an opportunistic place to identify and commence comprehensive geriatric assessment (CGA)⁵ and the appropriate interventions for those older people with conditions such as falls, cognitive impairment and frailty (The British Geriatrics Society 2012). They suggest that specific AMUs for the care of older people, Acute Geriatric Units, are better alternatives for older people as they have been shown to reduce the risk of functional decline and increase the probability of returning home. However these haven't been compared directly to AMUs in the UK. Many UK AMUs have specific frailty or geriatric multidisciplinary teams for older people (The British Geriatrics Society 2012).

AMUs are well established services in UK hospitals and are regularly visited by older people (Scott et al. 2009; Conroy & Cooper 2010). The evidence around the care of older people in AMUs needs further investigation. Although data on readmissions and other more organisational concerns is present in the literature, in-depth exploration of the lived experience, culture and impact for patients, relatives and staff is required. Now, more than ever, AMUs are being used to assess, treat and discharge older people within a very short time frame. It is likely that the AMU in the

⁵ Comprehensive Geriatric Assessment is the gold standard framework for assessment that covers a number of key domains relevant to treatment for older people, especially those with frailty. See: Conroy SP, Stevens T, Parker SG and Gladman JRF (2011) A systematic review of comprehensive geriatric assessment to improve outcomes for frail older people being rapidly discharged from acute hospital: 'interface geriatrics'. *Age & Ageing* 40(4): 436-443

study by Latimer (1999) may no longer represent the AMUs found in the NHS today. It is therefore necessary to focus upon the experiences and processes within this setting as organisations continue to focus and reorganise hospitals using the short stay model.

2.5 Chapter Summary

This chapter has begun to provide a background for some concepts and information which influence discharge decision-making for older people in the AMU environment. Some key concepts and theories regarding older people's acute care have been introduced and these will be referred to later to help situate the findings of this project. Concepts such as independence and autonomy will be crucial in the understanding of discharge decision-making processes. It is clear that acute care for older people especially in short stay units is a concern with little specific in-depth explorations of the experience, culture and impact on patients, relatives and staff. Instead, as the frequency of AMUs have grown, there has been an over-reliance on quantitative, target driven audit and investigation instead. The next chapter will introduce the policy background surrounding discharge decision-making and discharge planning for older people in acute care settings.

Chapter 3: Involvement and shared decision-making for health care decisions in health care policy

3.1 Introduction

This chapter provides an introduction to the UK policy that underpins discharge decision-making for older people in the AMU. In Chapter Two the initiatives of the NSF citing older people as having the ability to be autonomous over care decisions was introduced. This message has been built on in more recent literature towards the call for increased involvement and shared decision-making. These calls will be introduced in this chapter so that the current thinking and expectations for discharge decision-making for older people is understood. This chapter begins by introducing the concept of patient and public involvement and its place in policy over the last 30 years.

3.2 Theoretical interpretations of patient and public involvement

Since its publication in 1969, Arnstein's ladder of citizen participation (Figure 1) has been widely cited as theoretical model of reference for public involvement (Gibson et al. 2012; Fredriksson & Tritter 2017). Despite its original focus on town planning it is commonly used in health and social care in the context of patient and public involvement (Gibson et al. 2012; Fredriksson & Tritter 2017). The eight rungs of Arnstein's ladder begin with '*manipulation*' and move through increasing levels of involvement to '*citizen control*.' These are then grouped within three themes of '*nonparticipation*', '*tokenism*' and '*citizen power*' (Arnstein 1969). In order for levels of participation to move up the ladder, the transaction of power to citizens increases (Arnstein 1969).

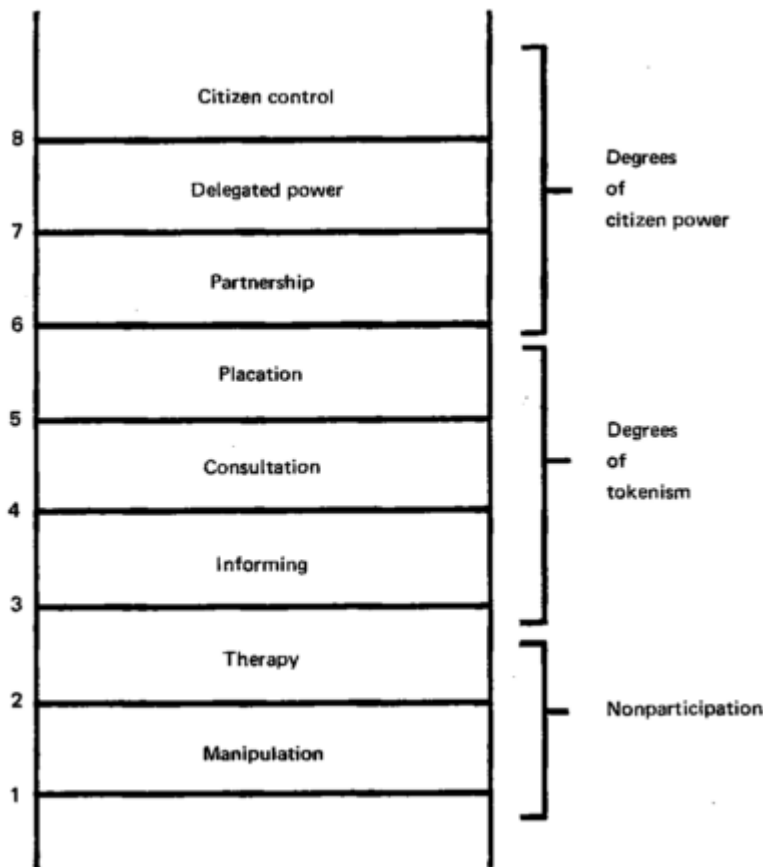


Figure 1 Arnstein's Ladder of Citizen Participation

Involvement in healthcare has a number of forms; patient involvement in health professional education, patient and public involvement in healthcare research and patient and public involvement in service evaluation, service development and organisation (Tritter 2009). Although these forms are distinct from one another in most respects there are interactions and relationships that cross them (Tritter 2009). Understanding how involvement is conceptualised in each of those distinct forms and as an overarching concept is complex. Tritter and McCallum (2006) highlight a number of faults with Arnstein (1969)'s ladder. Firstly, they comment that the ladder does not reflect the different actors, processes and outcomes that are necessary for enacting and evaluating involvement and instead over-focusses on the transfer of power (Tritter & McCallum 2006). The hierarchal structure is too simplistic and has numerous 'snakes' that reduce its' usefulness (Tritter & McCallum 2006). One 'snake' is that the 'tyranny of the many' is the ruling factor in 'citizen power' which does not ensure that the needs of the individual are met if their needs are in contrast to the need of the many as may often be the case (Tritter & McCallum 2006). This is contrary to continual mission statements within the English NHS that care should be person-centred as well as the growing societal ideal of individualism and independence. This focus on power and hierarchal involvement may not capture the many guises of patient and public involvement, but Gibson et al. (2012) reflect that not acknowledging it at all could lead to a lack of any empowerment. Therefore the public and patient may be involved and yet do not have

the means or capability for their efforts to influence. Power and trust in public and patients is necessary for influence to occur (Gibson et al. 2012).

To capture the different forms of involvement within healthcare as well as the nuance of the appropriateness of involvement for any given issue or decision, Tritter (2009) proposed an alternative conceptual framework to counteract a perceived over-reliance on the simplistic Arnstein (1969)'s ladder.

	Direct		Indirect	
Individual	Proactive	Reactive	Proactive	Reactive
Collective	Proactive	Reactive	Proactive	Reactive

Figure 2 Tritter (2009)'s conceptual framework for patient and public involvement

In this model, direct involvement would entail the actual involvement of the patient or the public in the decision-making process (Tritter 2009). Indirect involvement, thus involves the healthcare staff information gathering (which may involve asking the opinions of the patient or public) but ultimately making the final decision, sometimes ignoring voiced preferences (Tritter 2009). This model (Figure 2) acknowledges that a patient's involvement in a decision about their care would be individual, reactive (as it would usually be initiated by the professional) and direct or indirect depending on the extent of the discussion (Tritter 2009). This model also acknowledges that to another degree, a user group campaigning for a local service redesign would be collective, direct and proactive involvement. Similarly a consumer group being interviewed by health professionals about a local service redesign would be collective, indirect and reactive (Tritter 2009).

In the context of this doctoral study, Tritter (2009)'s model that separates individual from collective and direct from indirect is more comprehensive and useful to assist in understanding discharge decision-making for older people.

3.3 Patient and public involvement policy

In recent years, public involvement in NHS services and strategies has been a prominent policy focus in the UK in tandem with policy priorities of increased consumerism, marketization and choice (Florin & Dixon 2004). Despite this, a recent systematic review that identified 19 studies of the impacts of health-care policy initiatives for increased public involvement concluded that the concept as well as the potential outcomes were ill-defined and benefits could not be confirmed (Conklin et al. 2015). In this section, the health care policy initiatives of the last 30 years will be

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described to illustrate the lack of clarity and specificity on patient and public involvement in healthcare.

One motivator for the increase in public involvement in the NHS is to ensure that it is democratically organised and responsive to the needs of all (Florin & Dixon 2004; Foot et al. 2014). However, another motivator is also the consumerist influence that aims to ensure the healthcare market fits the needs and wants of the consumer (Foot et al. 2014). There is then a tension when discussion of marketization and choice – consumerist notions – occur alongside considerations of the democracy of healthcare. These are opposing notions with different outcomes and therefore likely to have differing approaches to patient and public involvement (Tritter 2009). A consumerism and choice focus on healthcare lends itself to individualism which is not in-keeping with decisions in a person's care that benefit from a collective approach (such as multidisciplinary involvement or population based commissioning) (Tritter 2009). Yet, policy initiatives do not appear to accommodate these two separate takes on patient and public involvement.

In the 1990s government initiatives for patient and public involvement were largely economically driven and this focus persisted during a change of government in 1997 as Blair's modernisation agenda pulled the focus towards quality of care and experience (Gibson et al. 2012). The publication of 'The New NHS: Modern, Dependable' in 1997 aimed to ensure accountability of the NHS to the patients and public and build confidence in the system by incorporating their views (The Department of Health 2004). In 1999 the publication of 'A first class service' aimed to shift care focus to patient-centred care with the introduction of the 'clinical governance' approach (The Department of Health 2004).

In 2000 the NHS Plan enforced the expectation that members of the public should sit on major decision-making boards such as the General Medical Council, the (at that time) NHS Modernisation Board, the Commission for Health Improvement and the Independent Reconfiguration Panel (Health 2000). Funding was redirected to the Patient Advice and Liaison Service and other 'new citizen empowerment mechanisms' to ensure that services were redesigned from a 'patient point of view' (Health 2000 p.95). Florin and Dixon (2004) criticised the policies set out in the NHS plan reporting that if the goal was democratic healthcare, the expectations and appropriateness of public roles had to be more rigorously explained and evidence-based. If the goal was to ensure an NHS that is responsive to the needs of patients, they felt more focus on alternative approaches such as patient involvement in individuals' own health and care decisions would be more meaningful (Florin & Dixon 2004).

The Labour Government made the concept of patient and public involvement into legislation in the 2006 NHS Act. This Act required every NHS Trust to establish patient forums to monitor and review the range of NHS services provided (Great Britain 2006). The NHS Act 2006 set out the functions of the Commission for Patient and Public Involvement in Health (Great Britain 2006). Throughout this Act, patient and public involvement appeared to mean only collective involvement and did not acknowledge aspects of individual involvement in care. In the same year, Lord Darzi was commissioned to complete a yearlong investigation into the NHS. It was at this point that the 'healthcare quality' focus was broadened not only to capture speed of care delivery, but also patient experience and other patient outcomes (Maybin & Thorlby 2008). Darzi reported that he had "heard the need to give patients more information and choice to make the system more responsive' and planned to give 'patients more control over their own health and care' (Department of Health 2008b p.10). The phrase patient and public involvement was not used throughout this report. This increase in control and empowerment was hoped to have a public health impact, "Patients empowered in this way are more likely to take greater responsibility of their own health" (Department of Health 2008b p.38). Darzi's use of 'control' and 'empowerment' terminology, in-keeping with the independence and individualistic societal rhetoric, was also used in relation to professionals leading change and improvements (Department of Health 2008b).

In 2010, a change of government and a Conservative-Liberal Democrat coalition brought with it the biggest NHS reforms in its history (Timmins 2012). The Health and Social Care Act 2012 saw the biggest shift of power and accountability to General Practitioners to act as patients' expert guides as they were forced to engage in commissioning processes alongside the abolishment of tiers of NHS leadership and management (Timmins 2012). The Health and Social Care Act served to bolster and re-affirm consumerism with its further encouragement of competition, choice and the involvement of the independent sector in healthcare (Timmins 2012).

A change of language was also noted. Patient and public involvement appeared to be replaced by "shared decision-making" which was at the centre of this policy with mantras such as '*no decision about me without me*' (Department of Health 2012a). In reality there was a lack of acknowledgement for how this would be implemented and instead this was only translated to a focus on choice – reflective of Darzi's report (Gregory et al. 2012). A lack of consideration of the complexity of the support and extensive training that health professionals would need to embed shared decision-making in practice systematically was an issue (Coulter 2012). Despite this flaw in the policy, the coalition government also continued to implement this message without capturing the complexity of what they were asking clinicians and the public to do. Coulter (2012) highlighted

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how clinical leadership was required to ensure patients saw more opportunities to share care and treatment decisions and ensure that the policy message was realised.

In the 'Liberating the NHS; No decision about me without me' consultation documents the intentions for shared decision-making to be common practice was clear (Department of Health 2012b)(Figure 3). They proposed a model of shared decision-making which largely focussed on primary care and specifically suggested that unplanned and urgent care may not be able to incorporate principles as readily – describing the need for a more technocratic approach in those areas where health professionals ensure patients receive the “correct” care needed at that moment (Department of Health 2012b). In the final chapter of the document, a plan for how shared decision-making would be achieved was made. Statements pertaining to improving staff education on shared decision-making, the introduction of 'choose and book'⁶ and the provision of clear and readily available information on services and options for patients were made (Department of Health 2012b). In response to this consultation, this focus on choice was criticised by the King's Fund who said it was 'extremely disappointing' as they felt that the document's over-focus on 'choice' was fundamentally not representative of the true complexity and benefit of shared decision-making (The King's Fund 2012). The King's Fund (2012) also argued that the document had oversimplified the level of leadership and educational initiatives that would be required to make 'no decision about me without me' a realistic goal.

⁶ Choose and Book refers to a system that allows patients to pick which service, hospital or clinician they see for outpatient appointments or diagnostics, rather than being referred to the most local service or the service that has a relationship to the referrer (Department of Health 2012).



(Department of Health 2012b p.13)

Figure 3 The Department of Health's model of shared decision-making all along the pathway

At the end of the coalition government, the NHS Five Year Forward View proposed the changes that needed to happen to make the NHS sustainable in the next 5 years. Within this they acknowledged that patients were reporting a lack of information and involvement in their health and care decisions (NHS England 2014). A commitment to the democratic motivations of patient and public involvement were evident with sections on 'empowering patients', 'engaging communities' and 'The NHS as a social movement' (NHS England 2014). To empower patients they hoped to provide better information on conditions but also patients' own care, investment in self-management programmes and committing to '*make good on the NHS' longstanding promise to give patients choice over how and where they receive their care*' (NHS England 2014 p.13). Again, empowerment to patients equated to the provision of choice. The direction of the Five Year Forward View was welcomed, particularly for acknowledging that one size does not fit all in terms of healthcare commissioning and organisation, however, the King's Fund warned that it had to be properly committed to these aims to create the policy changes and have them implemented effectively at a local level (Ham & Murray 2015).

Most recently, in a review of progress and work still left to do following the Five Year Forward View, NHS England showed further commitment to the democratic nature of patient and public involvement. It reported that things like hospital closures could not occur unless there are assurances that it is in keeping with patient choice and that patients and the public are engaged in

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the closures (N.H.S. England 2017). Arguably, this is naïve as it is rare that a community would choose for their local hospital to be closed. This report also highlighted a necessity for focus on specific challenges in the context of a 'modest funding increase', specifically A&E performance, access to GP services and improvements in cancer and mental health (N.H.S. England 2017). However, a specific discussion of community engagement still prevailed – citing the necessity of this for the integration of future services. To this end, collective patient and public involvement still appears to be a priority – but patient involvement, shared decision-making or even choice have slipped out of focus in this 2017 report.

The policy pattern of recommending patient and public involvement and shared decision-making but not grasping the complexity of the concept or providing adequate information about what it would look like in practice is noteworthy. What was bred out of a wish for transparency, representation and democracy became something that hinged on technocratic approaches to healthcare delivery and relied on expert involvement not patient and public involvement (Martin 2008). Patient and public involvement was enforced initially through NHS target culture without focus on its impact on organisational policy, healthcare practice or professional cultures (Tritter 2009). None of the policy initiatives have acknowledged the time that it takes for trust to be developed and patient and public involvement to manifest (Tritter 2009). The theme of choice being used synonymously with patient and public involvement throughout policy also does not progress the original aims; creating a system that meets the needs of those that use it and is shaped by their experiences. Instead this promotion of marketization and consumerism within the 'choice' rhetoric limits the evolution of patient and public involvement (Tritter 2009).

In summary, calls for patient and public involvement in healthcare delivery and practice have been consistent within policy over the last 30 years. Despite this, a lack of detail and full commitment has been seen as well as confusion in translating this to practice and the dilution of the message with choice and other more consumerist notions. Most of the efforts in recent times, have been largely centred on democratic, collective, public involvement and it appears to now be imbedded that this is necessary for re-organisations of healthcare to take place. Patient involvement appears to be secondary in terms of priorities. It is expected that this may be associated with the more tenuous link between individual, patient involvement and efficiency and money-saving. As NHS England indicates, difficult choices and prioritisation is needed when finances in the health service are limited (N.H.S. England 2017).

3.4 Policy on discharge planning and older people's care

Discharge planning has been a focus of attention for policy makers, clinicians and patients for many years. This section will discuss the policies related to older people's care and discharge planning to improve experiences and quality. The broader policy trends reflecting patient and public involvement as detailed above and similar issues relating to translating the policy into practice have been observed. This has led to many reiterations and repeated recommendations.

In the context of the Five Year Forward View, most recently the National Audit Office (2016) has reviewed the issue of discharges for older people in order to highlight how the NHS has not been achieving the efficient discharges that have been repeatedly recommended. This led to the issue of hospital discharge for older people being discussed at length by the House of Commons Committee of Public Accounts (2016). MPs from many constituencies across the UK attended highlighting the widespread nature of the problem. The report by the National Audit Office (2016) highlighted the extent of the issue. They concluded that 1.15 million bed days were lost due to delayed transfers of care, 2.7 million hospital bed days were occupied by older people who no longer were in need of acute treatment and the average length of stay for older patients in 2014-15 was 11.9 days (National Audit Office 2016 p.4).

In the report that followed it was acknowledged that although improvements in discharge planning had been made in some circumstances, organisations such as NHS England and the Department of Health relied too heavily on different local circumstances as an excuse for the poor performance nationwide (House of Commons Committee of Public Accounts 2016). Particular frustration was held with the lack of integration of the health and social care sectors⁷ meaning that discharges were held up because necessary community based social support was not available or deliverable in a way that fitted with hospitals' discharge planning.

In the committee's report best practice for older people's discharges was acknowledged to be; 'avoiding older people being admitted to hospital unnecessarily, starting assessments and discharge planning early, maintaining the momentum of treatment while in hospital, joint/shared patient assessments between health and social care providers and undertaking the assessment of patients' long term needs in more appropriate settings, preferably their own home' (House of Commons Committee of Public Accounts 2016 p.6). The committee described the uptake of these best practices as 'patchy' across the NHS. The report made a number of recommendations focussed on financial incentives, restructuring, integrating and reorganising (House of Commons

⁷ This was a main recommendation from the NSF for older people back in 2001.

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Committee of Public Accounts 2016). The King's Fund called the report 'a wake up call' for local services to improve the care they provide for older people (Murray 2016).

Productivity in NHS hospitals was investigated by Lord Carter of Coles (Carter 2016). Within this review, issues of patient flow and delayed transfers of care were also identified to need great improvement. However many of the causes for poor flow appear similar to what has been recommended by the House of Commons committee above. Delayed patient flow was determined to be due to staff 'working within a system where incentives and processes around transfers of care are not always clear and rarely fully aligned.' (Carter 2016 p.65). Perhaps then the increase in incentivisation of discharge planning, previously recommended, will only make this worse. Carter (2016) recommended that the Department of Health, NHS England and NHS Improvement should work with local government to provide a strategy to help ensure that patient pathways run smoothly with measures and incentives at the 'correct points'. Again, recommendations for improvements were situated more around organisational changes rather than changing the approach to care and involvement.

Previous policy appeared to have a more patient centred approach to improvement. Just as standard two of the NSF called for older people to be involved in all care decisions and have autonomy for the level of risk they'd like to take, the NAO highlighted how integral the involvement of older people and their families was to ensuring efficiency (Department of Health 2001; National Audit Office 2003). The NSF's standard four stated that discharge planning should meet the individual needs of patients and that planning should be commenced from the very beginning of a patient's admission (Department of Health 2001).

An independent review took place to ascertain if any improvements had been made since the publications of the NSF by the Commission for Healthcare Audit and Inspection (2006). Within this, poor discharge experiences where patient wishes and preferences were not a focus were reported (Commission for Healthcare Audit and Inspection 2006). The Commission for Healthcare Audit and Inspection (2006) recommended components of discharge planning to ensure further improvements were made including the active involvement of patients, family and carers in discharge planning. Indicating minimal evidence of improvement, these same components were then reiterated by the Department of Health (2010) in their discharge specific "Ready to Go?" document. The NAO's message that adequate involvement of patients and relatives would help meet organisational and efficiency targets was also reaffirmed in a tool focussed on freeing bed capacity and reducing length of stay (N.H.S. Institute for Innovation and Improvement 2011).

In contrast, focussing on efficiency and capacity instead of focussing on patient's individual needs was the main criticism of one NHS Trust during the Francis report that investigated the Trust's

failings in safety and patient experience (The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). During the report Francis identified instances where patients were discharged without confirmation that their care was due to start and without their wellbeing followed up after discharge by any health or social care professional (The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). Despite this message highlighting the need to take focus away from efficiency, the Francis Inquiry led to the Keogh report into patient safety in hospitals. In this, Keogh determined that the NHS was experiencing unprecedented demand and as such had to focus on urgent care pathways and efficient discharges (N.H.S. England 2013).

These most recent reports and policy thinking show that the priority currently is with increasing and easing the flow of patients through hospital systems (National Audit Office 2003; National Audit Office 2016; N.H.S. England 2017). Although involvement and shared decision-making for care decisions may be one approach that helps towards that agenda, there is an over focus on financial incentives and reorganisation in current policy that may reinforce the same conditions that lead to the unnecessary poor treatment of patients discovered in the Mid-Staffordshire Inquiry (The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). In the context of the “modest funding increase” that led to the Five Year Forward View re-prioritising some of its’ aims, organisational change has once again become the focus (N.H.S. England 2017).

It is clear from this timeline of policy related to older people’s care and discharge that requirement for focus on organisational flow, early discharge planning and patient and relative involvement are reiterated and repeated. These repetitions show that improvements and changes have been limited in the last fifteen years and that the issue appears to have grown in significance. The need to improve patient and relative experiences cannot be viewed as mutually exclusive of effective procedures and efficiency in the current political climate where public spending is stretched and reduced. The issue of discharge planning for older people remains relevant politically and has been at the forefront of much media, public and political debate. Much of the policy focussing on organisational and system needs apply to the patient population more generally but becomes particularly important for older people as the largest user group of acute services (Conroy & Cooper 2010). What remains unclear is why these well-established recommendations are not being adopted and why policy reviews continually indicate a picture of failure in these areas. Policy needs to be consistent in both its commitment to efficiency and to improving quality of care and experience as well as the role of patient involvement or shared decision-making within this.

3.5 Professional recommendations for discharge planning – supporting older people to make decisions

Policy think tanks and professional bodies consistently recommend that older people should be supported to be involved in decisions around discharge (Royal College of Psychiatrists 2005; The British Geriatrics Society 2012; Age U.K. et al. 2015). This section introduces some of these recommendations and investigates if these aid in defining how this is achieved in acute care for older people when policy so far has not.

The Darzi report for the Department of Health (2008a) that highlighted further need to focus on improving patient experience, triggered the development of guidelines for improving the experiences of adults in the NHS by the National Institute for Health and Care Excellence (N.I.C.E. 2012). These guidelines specified that all adults should be treated with dignity, compassion, courtesy, respect and honesty. Specific to decision-making, it was asserted that decisions about health and care should be shared decisions where patients are informed and enabled to make care decisions that reflect what is important to them (N.I.C.E. 2012).

In the same year the “Silver Book” was published by the BGS which resulted from collaboration between a number of different stakeholders and providers of older people’s care (The British Geriatrics Society 2012). It aimed to deliver a comprehensive guide on ways to ensure quality in urgent and emergency care. They highlighted that a whole system approach was needed to address the pressing concerns being continually raised about older people’s care in acute hospitals. The guide is comprehensive and six standards specific to discharge planning were set. The first set out that discharges should be undertaken with support and respect for patients’ preference. In addition it was recommended that “older people, and where appropriate their carers and families, should be involved in the decision-making process around assessment and management of on-going and future care, and self-care” (The British Geriatrics Society 2012 p.13).

More recently, good discharge planning and post discharge support was once again recommended in guidelines by the King’s Fund that looked to equip the health service to better cope with an ageing population (Oliver et al. 2014). More specific guidance was given on the involvement of patients and their relatives in identifying goals and potential issues for discharge as well as in formulating a discharge plan (Oliver et al. 2014). However this document does not focus specifically on how this can be achieved, except in recommending one key person in an MDT for relatives to liaise with.

Age UK et al. (2015) created a narrative report using the experiences and preferences of older people on what they expect from health and social care. This led to the creation of a set of ‘1

statements' expressing these expectations across the areas of community interaction, independence, care and support and decision-making, themes that heavily mirror those found in Bridges et al.'s (2010) systematic review. The decision-making statement can be found in Figure 4. The statement is strong in message, acknowledges that sometimes support is needed to make decisions but puts the control and responsibility for such decisions with the older person. It aligns with aforementioned calls within research for a relational approach to decision-making (Bridges et al. 2010; Patterson et al. 2011).

Decision making:

I can make my own decisions with advice and support from family, friends or professionals if I want it

Figure 4 Decision-making "I statement" from Age UK et al. (2015) narrative

3.5.1 Shared discharge decision-making

Whilst there are consistent calls for older people and their family to be involved in decisions, there is limited explanation of what that should look like in practice around discharge decision-making. The NICE guideline for patient experience in Adult NHS Services, suggests that shared decision-making occurs where a partnership is formed between health professionals, older people and relatives and patients are encouraged to make well-informed decisions that reflect their own preferences (N.I.C.E. 2012). Most recently a 'Shared Decision-making collaborative' has been set up by NICE along with over 40 organisations showing a longstanding commitment to the necessity of improving the uptake of shared decision-making practice (N.I.C.E. 2016). In this, it was acknowledged that initiatives to date have not achieved much more than 'words on a page' (N.I.C.E. 2016).

Shared decision-making can be seen as an ethical requirement in care as part of a philosophy that balances individuals' preferences and wishes as equal value to scientific knowledge (Da Silva 2012). It is acknowledged that professionals and patients bring different contributions to each decision in health, but it is hoped that in shared decision-making both sets of knowledge types are valued and considered equally (Foot et al. 2014).

This quotation from Da Silva (2012 p.i) makes it clear how this approach values patients as individuals;

“Thus, shared decision-making is necessary because I, and only I, in the context of my life, my relationships and my capabilities, can decide what will best meet my needs from the choices available to me”

This acknowledges the interdependency of individuals on others and is in alignment with relational approaches to care and autonomy as mentioned in the previous chapter.

In a King’s Fund report shared decision-making is considered an aspect of involving patients in the NHS generally alongside engaging people in healthy lifestyles, supporting self-management, having personal health and social care budgets, choosing providers and taking part in research relevant to your care (Foot et al. 2014). Here, the inter-related motivators for increased involvement in health care generally are listed, including the ethical reasoning explained above.

Between the Health Foundation and King’s Fund reports the stages involved in shared decision-making are described differently. Congruent between them is the need for information exchange between all partners in the decision, deliberation where feedback and reactions are gained, understanding is checked and a joint decision is made and finally, agreeing to, documenting and implementing the course of action (Da Silva 2012; Foot et al. 2014).

In order to facilitate shared decision-making in practice a number of tools are suggested including written and electronic information for patients, patient held and electronic records, decision aids, action plans, communication tools and individual education and coaching (Da Silva 2012). It also identified that some studies have investigated ways to target professionals to help them improve their shared decision-making practice, but identified that no empirical studies were found that focussed on interventions based on organisations or environments that could promote a change in culture around clinical decision-making (Da Silva 2012). Da Silva (2012) acknowledges that further research and definition of shared decision-making is needed as there are many barriers to its’ widespread use for all clinical decisions. Shared decision-making as a partnership needs both parties, clinician and patient, to be interested in, motivated for and aware of shared decision-making and what it entails. Some research purports that older people in particular are less interested in active involvement in their care and prefer a paternalistic approach to health care. This very notion, disproved by Age UK’s aforementioned ‘I statements’ provides one of the largest barriers that needs to be overcome before shared decision-making is ingrained in current practice (Da Silva 2012).

In a systematic review of older people’s experiences of shared decision-making for all healthcare decisions, barriers were identified to be broadly associated with how the system is organised and how interactions with the clinicians occurred (Joseph-Williams et al. 2014). Themes such as trust, terminology, inappropriate environment and a power imbalance were reported (Joseph-Williams

et al. 2014). The key message in Joseph-Williams et al. (2014)'s review was that information provision does not constitute shared decision making, nor does it affect the power imbalance that is evident in patient-clinician encounters. This acknowledgement of the need to consider power and thus, empowerment, links back to the earlier discussions on patient and public involvement. However, still an explicit definition of what shared decision-making looks like either for older people or in acute care has not been achieved.

3.6 Chapter Summary

Within this chapter the UK policy context surrounding discharge planning has been explored. The concept of patient and public involvement has been described and two models for its conceptualisation introduced, Tritter (2009)'s matrix and Arnstein's (1969) ladder. Tritter's manages the nuance between patient and public involvement and Arnstein's manages the transfer of power that enables patients and the public to make decisions. Overall, it was concluded that Tritter's model would be most useful for application to discharge decisions for older people. Throughout the policy on public and patient involvement, greater attention has been paid to public engagement than patient specific decisions. Despite this, consistently throughout professional recommendations the increased involvement of older people in care decisions and specifically discharge decisions has been called for, to improve both organisational efficiency and patient experience. One such recommendation for increasing patient involvement is shared decision-making, of which the definition appears to acknowledge and encompass interdependency and a relational approach to autonomy and care. However, shared decision-making is not adequately reflected in the general healthcare policy trajectory towards increase in individual's responsibilities for their own healthcare. Latest policy focus and attention has moved away from focus on involvement as the system struggles to manage patient flow and delays are frequent. This current rhetoric does not help in tackling over 15 years' worth of repetitious policy recommendations regarding improving older people's care, shared decision-making and discharge planning. The following chapter provides a systematic search of the existing literature on the subject of discharge planning and then more specifically of discharge decision-making for older people. The extent to which involvement and shared-decision making are apparent within current experiences will become clear.

Chapter 4: Reviewing the literature

This chapter presents the findings of a broad search of the literature on discharge planning for older people followed by a focussed systematic synthesis of older people's experiences of the discharge decision-making process. There is a considerable amount of literature published on discharge planning for older people. There is limited literature available specific to discharge planning on the AMU or other short stay hospital environments. Therefore this literature review is approached in two parts. It begins by providing an overview of the literature on discharge planning for older people. This body of literature is vast, varied and complex. Then, an in-depth narrative synthesis on older people's experiences of discharge decision-making is presented, following identification of the gaps in understanding in the critical overview. The results are presented below.

4.1 Discharge planning for older people

Discharge decision-making is an integral part of the discharge planning process. Discharge planning for older people has long since been an area of focus for research in attempts to ensure quality of care and efficiency.

The aim of this literature review section is;

- To present an overview of the existing literature on discharge planning for older people
- To understand and explore what is meant by the term 'discharge planning' for older people
- To synthesise the current approaches to investigating discharge planning in the acute hospital environment
- To identify potential gaps in the existing knowledge on discharge planning in the acute environment for older people.

4.1.1 Search strategy: discharge planning for older people

In order to capture a broad overview of the existing literature this search included articles based in any country that were written in the English language. This was to enable a wide scope of the international knowledge on the topic. One search was conducted on the 21st May 2015 using the DelphiS search interface. This interface is specific to the University of Southampton and found results from following databases;

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- Science citation index
- Social sciences citation index
- Medline
- CINAHL
- Science Direct
- PsycINFO
- SocINDEX
- Scopus
- SPORTDiscuss
- Buisness Source Premier
- JSTOR Journals
- SciELO
- Informit Health Collection
- ePrints Soton
- GreenFILE
- Directory of Open Access Journals
- PsycARTICLES

The search terms used were (Older People OR elderly OR older adults) AND (Discharge OR Discharge Planning OR Discharge Process) AND (Hospital). These terms were selected as they were considered Keywords on the DelphiS interface. This search initially yielded over 26,000 results. As the aim of this search was to gain a broad overview rather than an exhaustive one attempts were made to condense the results to a more manageable number. The search was restricted to articles that had gone through a peer review process and those that are available through the University of Southampton's institutional access. This reduced the results to 16,821. The inclusion and exclusion criteria for the articles in this review were then formulated (Table 1).

Inclusion Criteria:	Exclusion Criteria:
<ul style="list-style-type: none">• Articles focussed on older people's care specifically (broad definition of 'older people' accepted).• Articles focussed specifically on the discharge aspect of care• English language articles	<ul style="list-style-type: none">• Articles focussed only on patient's needs after discharge• Articles solely on patients being discharged to nursing facilities, nursing homes or other hospitals.• Articles focussed on readmissions without discussion about the discharge process

Table 1 Inclusion and exclusion criteria for literature review

Results were re-ordered so that the most relevant to the search terms were listed first. From this, a sweep was completed of the first 350 results. Following this, a second search was completed this time with the term 'discharge' removed. (Second search terms; (Older People OR elderly OR older adults) AND (Discharge Planning OR Discharge Process) AND (Hospital)). This second search yielded 110 articles. The full process for this search strategy is illustrated in Figure 5. The results from search 2 and the sweep of search 1 were reviewed according to the inclusion and exclusion criteria (Table 1). The included articles were then added to an existing library of previously collected citation and hand searched articles stored in an EndNote library. The articles were all then uploaded to QSR NVivo 10 data management software. At this point the full articles were screened according to the inclusion and exclusion criteria and a further 67 articles were excluded. The articles were excluded if they were not considered empirical research, were editorials, study protocols only or were not deemed relevant to the aims of this review. The annotation and coding features of NVivo were used to assist with critical appraisal and the identification of findings and methodological approaches. The software was also used to categorise findings and shape analytical interpretations.

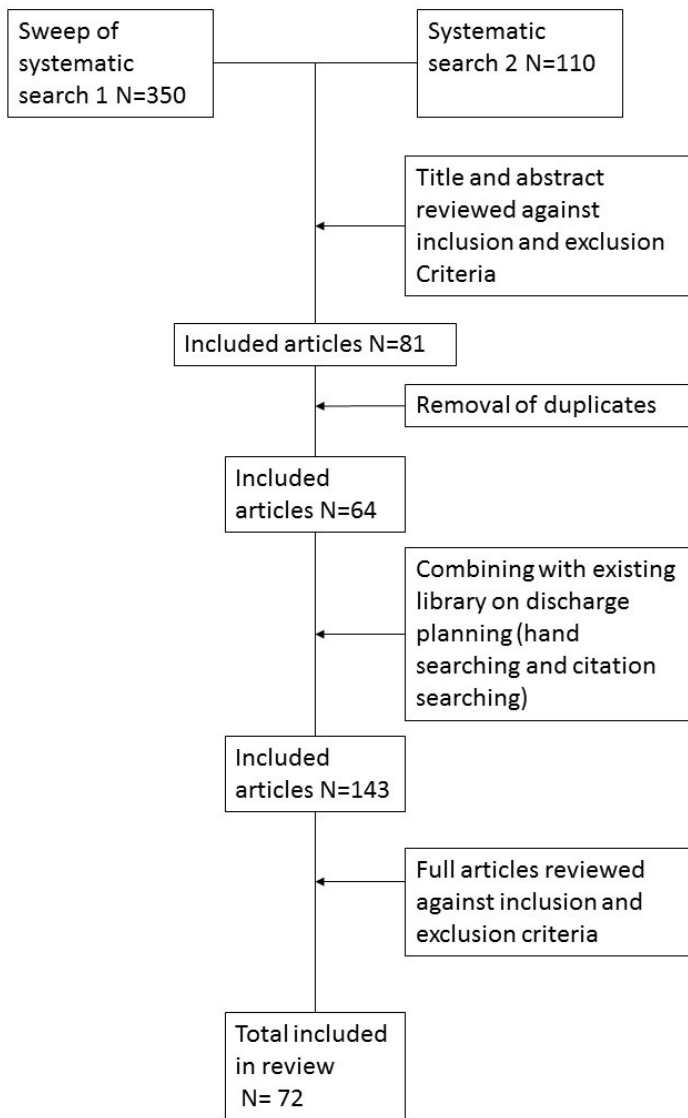


Figure 5 Literature Search results flow diagram

4.1.2 Summary of studies

Seventy-two studies were included and reviewed. The articles were published between 1992 and 2016. The methodological approaches used to understand discharge planning for older people were varied and included literature reviews, randomised control trials, interventions studies, ethnographic studies, questionnaires and many other methods and methodologies.

The diverse nature of the discharge planning literature meant that drawing any conclusions or consensus from these results was problematic. Research approaches, interpretive frameworks, methods, outcomes, aims and analysis were rarely consistent between studies. In addition, many studies were set in a number of different countries with very different healthcare systems and organisations including; the UK, republic of Ireland, USA, Canada, Finland, France, Hong Kong,

Israel, Norway, Sweden, Switzerland and Taiwan. Findings are organised here using the following categories; definitions of discharge planning, literature exploring the barriers to organising discharge, literature understanding the experiences of those involved in discharge planning, literature on interventions to improve discharge planning and finally literature addressing how discharge decisions are made.

4.1.3 Contributions of the literature to defining discharge planning

One purpose of this literature review was to understand, unpick and identify an explicit definition of discharge planning before specifically focussing on the decision-making element. Across the literature, there was not an accepted universal definition of discharge planning that was consistently used, despite it being a much debated and researched phenomenon. Few papers identified in this review sought to define discharge planning. In a Cochrane review, discharge planning was defined as *'the development of an individualised discharge plan for a patient prior to them leaving hospital for home'* (Shepperd et al. 2010 p.6). This definition, although clear, is necessarily broad to identify a variety of discharge planning interventions for inclusion in the Cochrane review.

Two articles sought to define discharge planning by building on their own empirical findings. One, a review of existing literature, concluded that discharge planning bridges the gap between care in the hospital and care in the community (Bauer et al. 2009). Bauer et al. (2009) explains that discharge planning should involve a complex process of assessment, developing an appropriate plan, provision of education and follow-up and evaluation. This review aimed to understand the existing best practice in order to ascertain how to improve outcomes for patients and family caregivers. Despite this clear aim and the confirmability of findings with other similar reviews, this review did not give any detail on the methods with which the research aim was achieved. No detail was given on search strategy, assessment of quality or numerical search results.

In contrast an ethnographic study using participant observation data sought to examine medical decision-making by exploring the role of discharge planners in an American hospital through a lens of bioethics (Dill 1995). It explored both the role of discharge planners and the concept of discharge planning at length. To summarise Dill (1995 p.1293) concluded that discharge planning is a *"socially produced activity where diverse interests are structurally joined and negotiated"*. In other words discharge planning is produced by the interrelationships of those who are invested in it (health professionals, patients, relatives) who may all have different interests and remits within a structure imposed by the organisation. This article was based on data collected in 1986 in a very specific context which may not be applicable to the modern AMU in the NHS. However Dill's

(1995) definition allows for the variability of discharge planning in every context and country depending on who is and is not involved. Alongside Shepperd et. al's (2010) broad definition, it identifies how discharge planning is inherently difficult to define, hence the lack of an accepted definition, due to the variability of context, situation and individuals.

Beyond defining discharge planning, Bull and Roberts (2001) identified four stages that set a standard of what they determined to be a 'proper discharge', one that was efficient, safe and effective. From the data they collected from interviews with health professionals, patients and relatives as well as documentary evidence they drew together the stages of what would occur in an ideal example (Figure 6).

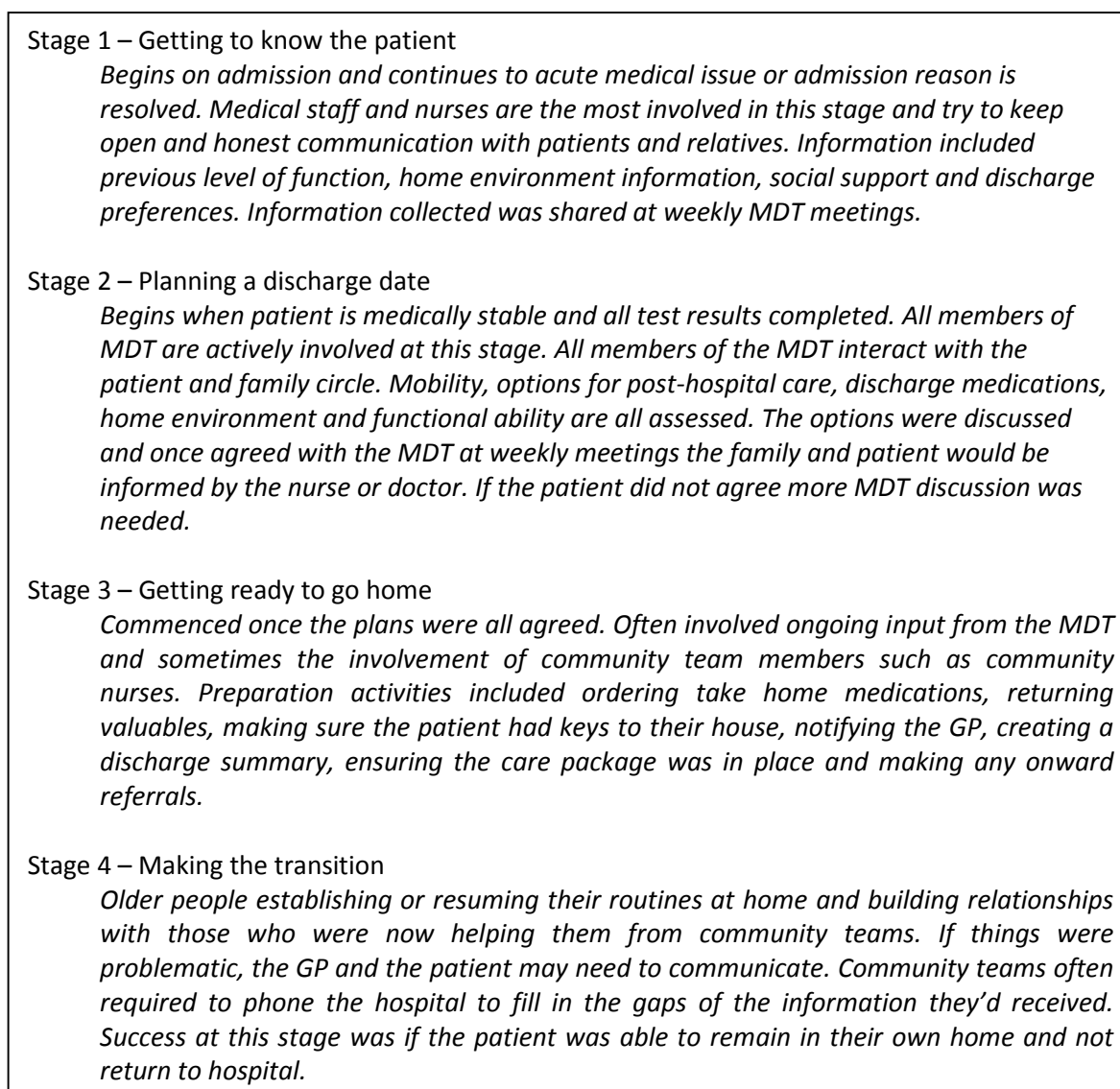


Figure 6 Four stages of a 'Proper Discharge' adapted from findings of Bull & Roberts (2001)

Although no consistent definition of discharge planning was used within the literature, standards for a 'proper discharge' have been extensively detailed by Bull and Roberts (2001). Other definitions are broad in their acknowledgement that the specifics of discharge planning are

difficult to be precise about as they vary depending on client group, organisation and location. Bringing the definitions of Shepperd et al. (2010), Dill (1995) and Bauer et al. (2009) together it can be agreed that discharge planning is a social process of developing an individualised plan for patients made following assessments and negotiation for them to leave hospital for home (or new home). This definition will be used to understand the remainder of the findings from this broad literature search.

4.1.4 The barriers to organising discharge; poor communication, disconnection with community services and organisational barriers

Frequently in the literature the barriers to successful or quality discharge became evident. These barriers were explored in both qualitative and quantitative literature. Following thematic analysis (as discussed in section 4.1.1) the most notable barriers included poor communication, poor relationships with community services, increased complexity of patients and organisational and environmental barriers. Understanding the existing barriers for discharge will inform the interpretation of findings in this study as well as allow for comparison.

4.1.4.1 Communication

By far the most consistent finding across the literature in this review was the breakdown in communication between inpatient and community teams (McKenna et al. 2000; Bull & Roberts 2001; Coffey 2006; Connolly et al. 2009; Davis et al. 2012; Chapin et al. 2014; Cadogan et al. 2016). In a review by Coffey (2006) it was concluded that the lack of connection between inpatient and community teams was evident in the literature and that this disconnection was impeding the quality of discharges. As acknowledged in Coffey's (2006) review, Bull and Roberts (2001) aimed to understand the components of a 'proper hospital discharge' for older people. In doing so they used interviews (Health professionals N=28, patients N=2 and relatives N=1) and the collection of documentary evidence from a rehabilitation hospital in South West London (Bull & Roberts 2001). Poor handover between inpatient and community teams was seen as a result of illegible discharge summaries, lack of understanding of district nursing roles and a lack of opportunity for open and continuous communication (Bull & Roberts 2001). The number of patients and relatives as participants in this study were disproportionate to the large number of health professional participants meaning that findings and themes cannot be assumed to represent their experiences.

In Coffey's (2006) review, a survey of practitioners showed that 68% of district nurses found handover and communication unsatisfactory and in some cases handover paperwork was described as inaccurate and inadequate (McKenna et al. 2000). Similar findings were reported by

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Davis et al. (2012) following focus groups and interviews with health professionals and administrators before the implementation of a new approach to care named the 'Care Transitions Innovation'. Participants reported absent and inadequate discharge summaries, a lack of interoperability of electronic systems and pressure on professionals to discharge people quicker leading to communication with community teams becoming a low priority (Davis et al. 2012). Davis et al.'s (2012) study was framed around the implementation of a new innovation which introduces potential bias. Analysis could have taken place in a problem-seeking way to ensure positive change in the findings following the intervention. However, the findings are confirmable with other experiences in different health care organisations, such as Sweden, where communication was found to be ad-hoc, informal and not a clear and defined process (Lundh & Williams 1997). In the UK context, issues of communication being compromised due to organisational pressures have also been reported (Connolly et al. 2009).

Focus groups were conducted with nurses, allied health professionals, social workers and one doctor by Connolly et al. (2009). Health professionals also reported resentment to the paperwork they had to complete including handovers and referrals as they felt they were being taken away from their caring duties (Connolly et al. 2009). In addition to communication with community teams, internal communication was seen as poor which often resulted in confusion and sometimes ignorance about a patient's care (Connolly et al. 2009). There was also concern that communication with older people was not sufficient as they were often deemed too anxious and distracted about going home to absorb the necessary information (Connolly et al. 2009). This finding is confirmed in Bauer et al.'s (2009) review which concluded that poor communication between patients, health professionals and relatives was one of the primary obstacles within discharge planning. However the participants included in Connolly et al.'s (2009) study were not representative of who would take responsibility for discharge. It was reported in the USA that the majority of responsibility for the final discharge decision was that of the doctors, of which there was only one participating in Connolly et al.'s study (Goldman et al. 2015).

As well as the communication in the build up to and eventual discharge of a patient being an issue, it was identified that information transfer on admission to the hospital was just as crucial to the discharge planning process (Bauer et al. 2009; Cadogan et al. 2016). Electronic records and records that follow patients through community and hospital care were therefore called for to address all of the above concerns – mirroring some aforementioned recent policy agendas (Da Silva 2012).

Another issue that was repeatedly discussed within the results of this review was the general lack of community services that can assist with the discharge process once the person is home with

many professionals feeling more community services would make discharges more successful (Bull & Roberts 2001; Connolly et al. 2009; Wong et al. 2011; Cadogan et al. 2016). Although the connection of this finding to discharge decision-making is difficult to ascertain, it is worth noting that this widespread issue adds context to some of the discontent often reported in health professionals' experiences of discharge planning.

The articles included in this review make clear that there are consistent reports of poor communication in discharge planning. The most consistent is the breakdown in communication that occurs between inpatient and community teams (McKenna et al. 2000; Roberts 2002; Coffey 2006; Connolly et al. 2009; Davis et al. 2012; Chapin et al. 2014; Cadogan et al. 2016). Additional issues with inter-professional communication and poor communication between professionals, relatives and patients was also reported (Bauer et al. 2009; Connolly et al. 2009). Applying these findings to the discharge decision-making process, it is therefore difficult to ascertain the impact of this poor communication and lack of joint working with community services on how decisions are made. Involvement and shared decision-making cannot take place unless all parties involved have the necessary information and are aware of the plans.

4.1.4.2 Increased complexity of patients

A number of articles commented that increased complexity of patients in recent times has caused discharges to be more difficult to organise. This is particular to the care of older people. As part of a prospective cohort study, Albrecht et al. (2014) collected information on demographics, psychosocial factors, discharge diagnoses, and medications using surveys and patient medical records to quantify the prevalence of non-comprehension and non-compliance with discharge instructions and identify associated patient characteristics. They concluded that social isolation was significantly associated with non-compliance with exercise instructions (Odds Ratio (OR) 9.42, Confidence Interval (CI) 95% 1.5 55.11) (Albrecht et al. 2014). In adjusted logistic regression models, one or more activities of daily living (ADL) disabilities (OR 3.44; 95%CI 1.44, 8.24) and self-reported history of diagnosed depression (OR 2.29; 95 % CI 1.02, 8.83) were significantly associated with non-compliance with medication instructions (Albrecht et al. 2014). Additionally, in adjusted logistic regression models, increasing age (OR 1.07; 95 % CI 1.04, 1.12) was significantly associated with non-comprehension of medication instructions (Albrecht et al. 2014). Despite these statistical patterns however, it is not clear that any of these patient factors cause non-comprehension or non-compliance and therefore it is not possible to conclude that the increased complexity of patients (with increasing age, ADL disability, self-reported diagnosis of depression or social isolation) has an effect on comprehension or compliance of discharge instructions. Additionally, the use of qualitative variables such as self-reported diagnoses and

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social isolation in statistical analysis evokes question on the reliability of these analyses. These findings pose questions regarding the suitability of services, care and the information provided to meet the needs of these participants as measuring concepts such as 'compliance' place blame with patients rather than potentially inflexible services and approaches.

To ascertain whether complexity impacts on discharge Challis et al. (2013) concluded that cognitive impairment was significantly associated with delayed discharge ($P < 0.01$). In addition dependence with feeding ($P < 0.01$), incontinence ($P < 0.01$), dependence with toileting ($P < 0.05$) and dependence with dressing ($P < 0.01$) were also factors that were significantly associated with delayed discharge. There was no significant effect on delayed discharge when patients were dependent with bathing or transferring. Dependency is arguably a qualitative term that is difficult to quantify but these results are logical as those with the most dependency in activities of daily living are likely to require the most community support that needs arrangement as part of the discharge plans. Despite some threats to the validity and reliability of some of the statistical analysis reporting that patient factors indicate increased complexity on discharge planning, the findings are confirmable with other studies (Wong et al. 2011; Chapin et al. 2014). The argument that complex needs increased need for services and length of stay and thus impedes or complicates discharge planning was also echoed in Bauer et al.'s (2009)'s review.

4.1.4.3 Barriers associated with healthcare organisations and discharge planning systems

A number of issues associated with healthcare organisations and systems have been cited as having a detrimental impact on the process of discharge planning (Fisher et al. 2006). Pethybridge (2004) aimed to understand team-working in discharge planning and whether professional cultures and models of practice influenced discharge planning. Using a grounded theory approach, observations, informal interviewing and focus groups were used to meet these research aims within stroke and respiratory wards in an acute hospital in London (Pethybridge 2004). Pethybridge (2004) concluded that the discharge planning process had been set up purely to meet the needs of the organisation and allow staff to process patients through the system. Therefore discharge planning in this context had not been devised to focus on the individual needs of patients. Pressure was placed on teams to process patients which caused discharges that professionals felt were risky and unsafe (Pethybridge 2004). It was also concluded that positive leadership was integral to promoting ward communication and positive behaviours (Pethybridge 2004). Pethybridge's (2004) article lacked some details such as number of hours of observation completed and any discussion on theoretical sensitivity or saturation which would be expected of grounded theory research. It therefore may not be possible to completely accept the conclusions. In particular, it is difficult to accept a proposal of 'four quadrants of leadership in discharge

planning' on the basis of research in two medical wards where the numbers of leadership styles observed would be limited (Pethybridge 2004).

Despite some lack of clarity in Pethybridge (2004)'s methodological approach messages regarding team-working issues, organisational barriers and system fractures are detailed and confirmable with other studies and reviews (Fisher et al. 2006; Wong et al. 2011; Davis et al. 2012; Cadogan et al. 2016). As well as systems not promoting discharge planning for individuals, Bauer et al.'s (2009) review identified an overall lack of any discharge planning systems.

Staffing was another organisational issue impeding discharge planning. Forty-four percent of health professionals in Connolly et al.'s (2010) survey reported inadequate staffing to adequately discharge patients. Articles by Davis et al. (2012) and Cadogan et al. (2016) conclude that poor staffing levels and inadequate skills mix have a detrimental effect of discharge planning.

Organisational expectations and targets were also seen to affect the way that health professionals could practice; one staff nurse reported, *"4 hour targets have an impact!! Patients are rushed out to free up beds, often resulting in them returning to hospital within a couple of days"* (Connolly et al. 2010 p.637).

Within this literature some of the barriers to discharge have been outlined. Communication is a clear issue both internally within hospitals but also with teams in the community. Increased complexity of patients was also identified as potentially adding delay and longer length of stay but it was not possible to draw absolute conclusions on this and argument could be made that the system needs to better adapt in order that these delays do not occur. It is however plausible that those with lots of health and social needs will have more discharge planning needs. There is evidence that suggests that the systems and structures in place organisationally do not encourage effective and good quality discharges or positive experiences in discharge planning. Further research focussing on this organisational and environmental aspect of care is therefore required.

4.1.5 Understanding the experiences of all those involved in discharge planning

Many of the articles found in this search sought to understand the perspectives and experiences of those involved in discharge planning; the patients, their relatives and care givers and the health professionals. Before further focus on discharge decision-making, it is important to understand what is currently understood about the experiences of all those involved in the entire discharge planning process. The experiences of older people in acute care generally were discussed in section 2.5 of this thesis.

4.1.5.1 Health Professional experiences of discharge

The subject of the involvement of older people in discharge was present and debated by health professionals in some qualitative studies in this review (Watts & Gardner 2005; Fisher et al. 2006). Health professionals reported feeling that older people were adequately involved in discharge planning but that this was dependent on their own willingness (Fisher et al. 2006). In Watts and Gardner (2005)'s study of nurse perceptions of discharge planning in Australia, nurses reported that patient's involvement in discharge could both enhance and impede the discharge planning process.

In Watts and Gardner's study, 12 registered nurses were interviewed over a period of 2 weeks. They deemed the discharge planning process to be a dynamic and ongoing process that primarily involved nurses 'planning' and 'organising' and the perception of the nurse role and responsibility for discharge planning varied for each participant (Watts & Gardner 2005). Although published 10 years later, the data reported were collected in 1995 and therefore may have limited applications to the nursing role in discharge planning now. A more recent study confirmed that nurses remain the co-ordinators and organisers in discharge planning and described the frustration as nurses needed to 'chase' and 'badger' other professionals such as care managers, occupational therapists and doctors in order to ensure discharge planning was completed (Atwal 2002). In multidisciplinary team meetings it was doctors that took the lead and spoke most convincingly on all issues related to care and discharge planning (Atwal 2002). This study used interview and observation data to explore nurses' perceptions of discharge planning as well as to identify the type of interactions which occurs in multi- disciplinary team meetings and their impact on discharge planning (Atwal 2002). Once again a variety of perceptions and expectations of individual nurses on their role in discharge planning was reported, particularly with regard to nurses who were inexperienced in discharge planning (Atwal 2002; Watts & Gardner 2005).

As well as articles focussed on nursing roles in discharge planning, the other professional group with specific focus in the articles in this review was occupational therapists. In Crennan and MacRae (2010)'s study 10 occupational therapists were recruited to take part in an ethnographic study using questionnaires and interviews. This study aimed to understand the occupational therapists' clinical reasoning behind discharge planning, what assessment tools were being used to assess older people and whether 'client-centred practice' was being adopted in discharge assessments. It was concluded that a standardised discharge assessment tool was not being used for assessment by any of the occupational therapists as the discharge planning process was different for all patients and often involved different information being available at different times (Crennan & MacRae 2010). As with the nursing focussed research, the occupational

therapists felt that collaboration and communication with other team members was crucial in completing the discharge planning process (Crennan & MacRae 2010). The study's objective of identifying the extent of 'client centred practice' is difficult to draw conclusions on from the findings in this study as it relied upon self-reported assessments and reflections in interviews. This objective may have benefitted from naturalistic data collection such as observation to triangulate the existing data and better situate the findings in context. Client-centred practice has been explored in other studies such as, Chapin et al. (2014) where it was concluded from the perceptions of discharge planners that achieving client-centred practice worked against the speed of discharges and the 'triage model' of delivering healthcare.

Additionally, Atwal et al. (2012) interviewed occupational therapists and physiotherapists to explore the idea of risk via a case vignette discussion at the end of an interview. Within the therapists' reports no consensus was gained on what the risks to the patient were. The main risks that the therapists were concerned about were risk of pressure ulcer development, risk of falling and risks related to cognitive decline (Atwal et al. 2012). Overall however the priority for discharge across the therapists' reports was the prevention and consideration of patients' safety and minimising risk (Atwal et al. 2012). Increasing safety and reducing risk also featured in an American study that sought the perceptions of discharge planners (Chapin et al. 2014). The usefulness of these articles that focus on particular professional groups is limited with regard to understanding aspects of older people's care. Not only is multidisciplinary and team communication widely reported within these studies as a facilitator and barrier to good discharge planning but it is widely accepted that discharge planning for older people should be a process involving all members of the multidisciplinary team and therefore research should reflect that (Dill 1995; Atwal 2002; Crennan & MacRae 2010; The British Geriatrics Society 2012). The most useful research on health professional experiences of discharge planning needs to acknowledge the multi-professional input required and even establish the interplay between professional groups and multidisciplinary teams.

As previously discussed, the study by Connolly et al. (2009) tackled this by inviting all professional groups to take part in focus groups. In addition to the findings regarding communication reviewed in section 4.1.4.1, the professionals discussed the conflicting pressures on them in discharge planning. They reported an innate pressure for swift discharges from the organisation, frustration as they tried to negotiate flexibility in a rigid organisational system and other frustrations from preventable delays and a lack of community services (Connolly et al. 2009). This pressure led to a sense of disillusionment and a negative impact on the professionals' sense of professionalism as well as a concern that patients were being 'systemised' as their needs were reduced and 'oversimplified' to fit the system (Connolly et al. 2009). This is a very similar finding to the

aforementioned study on acute care by Maben et al. (2012) (discussed in section 2.3) that identified that staff experience affected the care delivered. In response to time constraints and other pressures, nurses had to prioritise certain patients, leading to the categorisation of “poppets” and parcels (those who Connolly et al. (2009) describe as systemised) (Maben et al. 2012). This phenomenon appears to transcend different healthcare systems as the finding of system pressures causing staff dissatisfaction in their work to discharge people was also found in an American cross-sectional qualitative study (Davis et al. 2012).

The concept that the existing hospital and discharge planning systems are limiting the effectiveness, health professional role satisfaction and patient outcomes due to their fragmentation and inflexibility is consistent in the reports of health professionals and spans both UK and USA healthcare contexts despite their contrasting organisation and funding (Connolly et al. 2009; Davis et al. 2012; Chapin et al. 2014). Further research is needed to unpick and describe the contexts in which this fragmentation and inflexibility occurs before improvements can be sought. There is also some concern that staff satisfaction may also affect patient’s discharge and care experiences which will require further attention.

4.1.5.2 Relatives and caregiver experiences of discharge

The voices and perceptions of relatives and caregivers in experiences of discharge were not as frequently represented in the literature reviewed here as those of older people or health professionals. Within what was sought, the most consistent theme was the role of relatives being to advocate for patients (Procter et al. 2001; Bauer et al. 2009; Popejoy 2011). In Popejoy (2011)’s study relatives described having to stay vigilant to what was going on so that they could ensure the smooth running of care and the completion of crucial tasks. Some relatives ‘took over’ the organisation of discharge support and made their own assessments on the level of support the older person would need, whether it differed to the patient’s self-assessment or went further than the care provided by the health services (Procter et al. 2001).

In addition to being advocates and organisers in the process, relatives also completed formal caring tasks to ensure the patient was set up after discharge including domestic tasks, driving and assisting with personal care (Procter et al. 2001). However in the discharge planning process if families reported they would provide care assumptions were often made about when and how much support would be given. In Procter et al.’s (2001) mixed-methods study that aimed to look at the patient-carer dyad at discharge, one case history in particular was used to illustrate the extent and impact of these family support assumptions. “Mrs Prince worked part time, her husband frequently worked away from home, she had two children... Mrs Prince looked after her elderly mother Mrs Jones... Mrs Jones was familiar to all the hospital staff...” Doctors described

Mrs Jones' discharge as "*very straightforward*" and the nurses said that "*the daughter arranges everything*" (Procter et al. 2001 p.212). Her daughter hadn't been aware that Mrs Jones may have been entitled to a social services' package of care and had been providing extensive support, living two bus rides away and juggling her own health needs, work and her family. Mrs Prince described the hospital staff as recognising she took lots of responsibility for her mother's care and then expecting her to be able to take on more. She reflected, "*I'd just like somebody else to take that off me a bit you know...*" (Procter et al. 2001 p.212). In the discharge process, little mention had been made of the options of social services input as the assumption had been that Mrs Jones' daughter would do everything despite the strain it was already causing. Similarly in Coffey's (2006) review it was acknowledged that notice of discharge was rarely considerate of relatives' other arrangements with work or other family life. The needs of the carers and relatives were subordinated by health professionals to the needs of the patients (Procter et al. 2001).

In addition, a Canadian study concluded that the responsibility for care was engendered, with daughters and wives having higher expectations placed upon them (Neiterman et al. 2015). One study focussed a group discussion around the costs to relatives of caring for family members. Relatives' answers showed loss of privacy when carers were hired, loss of financial resources, increased costs of transportation and the loss of time for personal needs (Feigin et al. 1998). Discharges were being planned without consideration of the needs of those supporting them (Procter et al. 2001; Coffey 2006). It would be expected that this could be avoided if shared decision-making or at least adequate involvement of relatives in discharge decision-making had occurred.

A cross-sectional questionnaire study in Norway found that there was a significant difference ($P=0.031$) between two generations with regard to opportunities to provide information about the patient's home situation (Bragstad et al. 2014). 50% of the younger generation found they had been given opportunity to provide information compared to 34% of the older (Bragstad et al. 2014). In addition to the marked generational difference the general pattern shows that relatives are infrequently given the opportunity to provide information. The study ranked participation with information provision as discussed above being 'level two'. 'Level one' was just receiving information and 'level three' was participating in the decision-making and problem resolution. Using a logistic regression model and controlling for other factors, the odds of caregiver participation at 'level three' were over twice as high in the younger generation than the older ($OR = 2.121, P=0.045$) (Bragstad et al. 2014). It is unclear why this may be. Neiterman et al. (2015) found that many caregivers cited having previous experience or knowledge on how to navigate the system meant that they became instrumental in assisting the patients. Those who had previously worked as nurses and social workers found their professional experience particularly

helpful (Neiterman et al. 2015). It may be that this tacit knowledge, more likely in younger, working age relatives may go some way to explaining the difference in involvement between generations. Another explanation may be potential ageism towards older relatives (in-keeping with the view of older as other as discussed in section 2.2) but it is not possible to draw conclusions on this. It appears that despite policy indicating the importance of involving relatives in discharge, it is not possible to fully understand the extent of involvement relatives have in discharge planning.

4.1.5.3 Older people's experiences of discharge

The most comprehensive picture of older people's experiences of the discharge process can be found in the narrative synthesis completed for the Social Care Institute for Excellence (SCIE) (Fisher et al. 2006). The synthesis was not intended to be an exhaustive exploration of the evidence available but their clearly explained and detailed electronic, citation and hand searching yielded 104 potentially relevant articles, 28 of which were included in the study after a rigorous process of reviewing relevancy, scoring strength of correlation to the synthesis aims and assessment of quality (Fisher et al. 2006).

Within this synthesis a consistent theme of low participation for older people was found. In all 15 studies that were deemed to 'strongly' correlate with the aim of the synthesis (studies that have primary focus on older people's experiences on hospital discharge, used open-ended methods and had thick description and analysis), authors discussed a willingness of older people to accept discharge plans made by others and a 'passivity' in the discharge process (Fisher et al. 2006). Some exceptions to this were described but these were seen as exceptional circumstances that were preceded by personality traits such as 'strong willed', 'articulate' and 'confident' (Fisher et al. 2006).

Perceptions of power and status provided some explanation for this lack of involvement as older people often reported not feeling able to be involved and saw health professionals as the ones who controlled and therefore influence the course of the discharge process (Fisher et al. 2006). Fisher et al. (2006 p.36) describe how this professional status and patients' deference to it is propagated by a number of factors; formal hierarchy, medical expertise, previous experience of the hospital system, levels of health and energy (i.e. feeling well enough to participate), education, social standing and the use of language. One criticism of the synthesis was based on the quality of reporting of qualitative studies generally as the socio-demographic details of participants were often not reported and therefore basic description of the populations represented by these experiences could not be provided (Fisher et al. 2006). Patient deference to professional status due to a lack of information and opportunity to receive information is a

confirmable findings from a more recent study (Greysen et al. 2014). Other studies also confirmed how older people described inadequate, confusing and missing information with regard to their discharge plans, instructions, care and medication changes (Tierney et al. 1993; Knight et al. 2013; Neiterman et al. 2015; Cadogan et al. 2016). When this information is conflicting between professionals, another issue reported in the narrative synthesis, the impact of patient experience is more unsettling and concerning for patients, especially in the context where they fully trust and defer to health professionals (Fisher et al. 2006).

In Greysen et al.'s (2014) study, 24 older people were interviewed about their discharge experience as part of a broader study that provided an intervention of pre-discharge visits by a discharge specialist nurse for Americans with low health literacy⁸, limited English proficiency or both. In this study older people identified a lack of information provided on the topic of recovery and returning to normal life. One man reported, "*we didn't know what questions to ask... what sort of things may be good for my recovery*" (Greysen et al. 2014 p.1558). The participants in this study fit the findings of Fisher et al. (2006) as their health literacy levels and limited English proficiency can also indicate low levels of education, social standing, lack of experience in a medical environment and difficulties with use of language that impact their ability to be involved in discharge planning. Fundamentally, the hospital experience is also a confusing one, especially for those without medical expertise or hospital experience (Fisher et al. 2006). Neiterman et al. (2015) described how older people also found it difficult and confusing to distinguish between doctors, nurses and therapists. For older people to be involved in discharge, the process and roles of those around them has to be easily understood.

The discharge experience was consistently described as one of anxiety and apprehension for older people (Fisher et al. 2006; Knight et al. 2013). These anxieties were interpreted as particularly apparent on issues that were a threat to a person's safety and independence such as whether or not they would be let home and whether they'll be able to manage when they get there (Fisher et al. 2006). The synthesis also focussed on older people's experiences following discharge home. Older people described having to adjust to a change in their abilities (i.e. reduced mobility to when they were last home) (Fisher et al. 2006). In summary Fisher et al. (2006) conclude that the adjustment following hospital discharge needs to be considered in a more long-term way in discharge planning by taking a '*life-planning*' approach which would underpin older people's need for information and support to best manage the change and uncertainty.

⁸ Health literacy refers to a person's ability to access, understand and use health care information and systems (Nutbeam 1998). This will be discussed in more depth in the second half of this chapter.

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The challenge of returning home to a '*disrupted reality*' was also a factor discussed by older people in Nieterman et al.'s (2015) study where the desire to get back to normal was made more difficult when domestic routines (purchasing food, doing laundry etc.) had been disrupted by their hospital stay. Additionally, older people reported finding physical elements of their home to not be conducive to recovery as they were inaccessible (McKeown 2007; Greysen et al. 2014). Those who had family to ensure extra help or that their home was well set up and organised felt less difficulty during discharge (Neiterman et al. 2015). The process of having to accept extra help when needed was also a difficult adjustment for older people with many feeling concerned by burdening those loved ones who now had increased responsibility (McKeown 2007; Perry et al. 2011; Popejoy 2011).

In both McKeown (2007) and Greyson et al.'s (2014) interview studies that postdate the SCIE review by Fisher et al in 2006, the impact of illness on older people's social lives was notable. The loneliness reported also resulted from bereavements of spouses' and friends as well as the inability to participate in social activities as they once did (McKeown 2007). The initial limitation on their social life after discharge was another aspect of recovery that older people often hadn't anticipated and they felt that more socialisation would have improved their recovery (Greysen et al. 2014). The contexts described in these two studies are markedly different to the NHS context and both were accompanied by an intervention or service that is not necessarily standard care in these contexts. Despite this the findings are congruent with earlier reports synthesised by Fisher et al. (2006) and give insight into what it feels like to be an older person adjusting to life back home after hospital admission.

The literature on older people's experiences of discharge planning has been captured, synthesised and well described within the review commissioned by the SCIE (Fisher et al. 2006). More recent studies also refer to similar findings of low participation in discharge planning, the anxieties and apprehension of older people around discharge planning as well as the difficulties in adjusting to life at home after discharge. A different approach to discharge planning that encompasses more long term planning and acknowledgement of these difficulties is advocated (Fisher et al. 2006). These findings provide important understanding of the experience generally of discharge planning for older people.

4.1.6 Interventions designed to improve discharge planning

Some of the studies in this review focussed on measuring interventions intended to improve discharge planning. There was great variance in methods and interventions measured. In 2010 a Cochrane review was carried out to determine the effectiveness of interventions that planned the

discharge of patients from hospital to home (Shepperd et al. 2010). They focussed on discharge planning's effect on length of stay, unscheduled readmissions, place of discharge, health outcomes, mortality, patient and carer satisfaction, healthcare costs and medication use (Shepperd et al. 2010). Twenty-one trials met all of the inclusion criteria for this review (Shepperd et al. 2010). One fundamental issue within this review is the difficulty determining the difference between discharge planning interventions and usual care. For discharges to occur in a usual care context, the discharge must have been planned to an extent.

Despite this, for those allocated (Number of studies =10) to discharge planning there was a significant reduction in length of stay (Overall effect $p=0.005$) when compared to non-individualised, standard discharge (Shepperd et al. 2010). They were unable to make any conclusions about effect of discharge planning on discharge destination due to insufficient evidence (2 studies measured home or residential home, 2 measured home or nursing home) (Shepperd et al. 2010). Four studies that investigated patient's functional status, quality of life and anxiety or depression did not publish follow up data and the remaining five showed insufficient evidence of a difference between groups (discharge planning and standard planning). However, it was not clear if power calculations had been completed and therefore results need to be reviewed with caution. In the review Shepperd et al. (2010) discuss that despite every included study explaining the difference between 'discharge planning' and usual care it was not possible to isolate the particular components to ensure the extent of the differences. As a result it was also difficult to assess the extent to which contamination may have been possible between control and intervention groups when studies took place in the same hospital or organisation. . From this review, although it does appear that structured discharge planning may have a positive effect on some organisational outcomes the true effect is not yet established (Shepperd et al. 2010). The review therefore calls for further research to develop a method for measuring the impact of delayed or inappropriate discharges on patients and bed capacity, continue to focus on readmissions and length of stay as outcomes, safeguard against contamination between intervention, if possible, and control groups and focus on contextual understandings that underpin the interventions and usual care (Shepperd et al. 2010).

In addition to the Cochrane Review, more recent systematic reviews have been completed regarding discharge for older people but with slightly different focusses (Fox et al. 2013; Allen et al. 2014). One of these is a meta-analysis of 'early discharge planning' (Fox et al. 2013). This study used the Cochrane collaboration's protocol and defined 'usual care' as any care that hadn't specifically started discharge planning early in the admission or in the acute phases of the patients' illness (Fox et al. 2013). Nine studies were included. No statistically significant effect was found on length of stay but meta-analysis of seven studies found that older people who

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experience early discharge planning were significantly less likely to be readmitted both one and twelve months after discharge ($P= 0.0003$) (Fox et al. 2013). The results of this meta-analysis do suggest that early discharge planning may be beneficial. However, it may be that those who experience early discharge planning are more healthy or easier to plan discharge for than others.

Allen et al. (2014) carried out a systematic review focussed on 'transitional care' for older people from hospital to home. Transitional care is defined as an intervention that promotes safe and timely care as patients transition from different levels of care or across care settings (Allen et al. 2014). It is not clear in what ways transitional care interventions from hospital to home are different to discharge planning interventions aside from the difference in terminology. It is accepted in this review that interventions that take place solely in the acute environment without follow-up in the community do not adequately prepare older people for discharge (Allen et al. 2014). Unlike in the reviews by Shepperd et al. (2010) and Fox et al. (2013), this review did not further combine, interpret or analyse the data from the included studies. However they reported that six of the included studies showed a significant reduction in re-hospitalisation for the intervention groups up to six months after discharge (Allen et al. 2014). Four studies reported significant improvement in patient satisfaction in the intervention groups (Allen et al. 2014). Once again, in this review the lack of explicit clarity between studies about usual care and intervention care was a concern that meant the full extent of these interventions' benefit could not be determined (Allen et al. 2014).

Although the three reviews presented here do suggest some level of positive effect of discharge planning or transitional care interventions on outcomes for organisations and patients, there isn't sufficient evidence to make concrete recommendations about the way care should be organised for older people. Issues associated with lack of differentiation between usual care and intervention group care and potential contamination across groups are consistent across the reviews. It may be that it is not practicable in the acute care environment to prevent these issues from occurring, which calls into question the usefulness of doing randomised controlled trials on difficult to define processes like discharge planning for older people. All three of the reviews agree that further research is needed to better qualify and quantify the benefits. It could be argued that it would be beneficial to further understand and examine what current practice looks like before rolling out potential interventions. None of these reviews have focussed particularly on the acute medical unit environment in discharge planning.

4.1.7 Proposed theories and approaches to discharge planning

Of the articles included in this review, a small proportion considered specific approaches to discharge planning in acute hospitals. Four studies focussed on how discharge planning occurred in practice by taking a naturalistic approach to the research (Dill 1995; Rydeman et al. 2012; Riva et al. 2014; Durocher et al. 2015). Two of these studies took an ethnographic approach (Dill 1995; Durocher et al. 2015), one completed an excursus of previously published research underpinned by lifeworld theory (Rydeman et al. 2012) and the other carried out a conversational analysis of nurse – patient interactions (Riva et al. 2014). These studies were based in Canada (Durocher et al. 2015), Switzerland (Riva et al. 2014), America (Dill 1995) and Sweden (Rydeman et al. 2012).

These naturalistic studies unpick the context behind some of the themes identified in this review such as stakeholder experiences of discharge as well as the barriers to effective discharge planning. Rydeman et al. (2012) discussed discharge as an experience of being ‘in-between’. Older people are contextually in-between because they find themselves in an environment of a hospital that they recognise but of which they have no control and little understanding (Rydeman et al. 2012). They are the embodiment of ‘in-between’ as their self-perception and normal independence is juxtaposed by the impact of illness, aging and their bodily fragility (Rydeman et al. 2012). Finally, they are existentially ‘in-between’ as they face ideas of death, altered life, losses and the realisation that some life-goals may never be fulfilled (Rydeman et al. 2012). Rydeman et al. (2012) discusses how this embodied, contextual and existential ‘in-between’ is influenced by patients’ life circumstances as well as their relationships with health professionals.

Relationships and interactions were the focus of the conversational analysis study by Riva et al. (2014). Focussing on the Primary Nursing approach to delivering care where one allocated nurse takes responsibility for co-ordinating and planning care, this study recorded 52 interactions from twelve patients’ care in one rehabilitation unit (Riva et al. 2014). They found that interactions tended to range from ‘reciprocal approach’ to an ‘individual approach’ (Riva et al. 2014). In the ‘reciprocal approach’ patient participation is manifest by the nurse asking for comments and opinions as the care is planned (Riva et al. 2014). In the ‘individual approach’ the participation is more conversational; ideas are proposed, discussed and agreed upon (Riva et al. 2014). The ‘individual approach’ has similarities with the policy expectation in the UK of shared decision-making and partnership. The article goes on to use these findings as evidence for why primary care nursing is an approach that should be adopted. This does not appear to be a well-founded conclusion that is grounded in the data. The findings are focussed on two approaches to discharge planning and discussion, rather than experience or effect of Primary Nursing in particular.

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Another approach to care that was discussed in relation to discharge was '*client-centred practice*' (Durocher et al. 2015). This ethnographic study involving observations of discharge planning meetings and semi-structured interviews highlighted that professionals often reported offering 'client-centred practice' but there were individual variances in what the concept meant (Durocher et al. 2015). One example was that client-centred meant allowing patients to do what they wanted as long as it was deemed to be safe by the professionals (Durocher et al. 2015). This approach to discharge planning, does not necessarily fit with either Rydeman et al.'s (2012) biomedically focussed non-participatory approach, nor Riva et al.'s (2014) 'reciprocal' or 'individual' approaches. It may be that an approach to discharge planning is not easily defined as it depends on too many factors; context, environment as well as the individuals (health professionals, relatives and patients) involved. Truly 'client-centred' approaches would be different for each individual and therefore could not be categorised or defined.

The idea that the approach to discharge planning and decision-making is dependent on relationships with healthcare professionals, as highlighted by Rydeman et al. (2012), was also reflected by Durocher et al.'s (2015) choice to interpret their data through the theory of relational autonomy. Relational autonomy, as discussed earlier in this thesis, positions autonomy as a competency that considers the influence of social networks and interdependence of individuals on each other as the basis for which decisions are made (Sherwin & Winsby 2011). They reported that relational autonomy theory allowed them a better understanding of client-centred care and as a result discussed that if relational autonomy underpinned practice perhaps health professionals would be able to deal with the ethical implications of discharge planning in a more client-centred way (Durocher et al. 2015).

Communication between patient and professional was also discussed by Rydeman et al. (2012). Here, it was concluded that when the professional is focussed on the biomedical model (or illness focussed) the need for patients to be involved in the health care process is not met (Rydeman et al. 2012). When this occurs, Rydeman et al. (2012) argues that patients and relatives lose their understanding and sense of coherence regarding the discharge process. In order to then protect themselves in the process, older people and their relatives have to adapt to the prevailing hospital structures or try to appeal to professionals' good will (Rydeman et al. 2012). This description of older people adapting to the fit the system is confirmable with other aforementioned studies (Latimer 1997; Jones 2006). However, this study is an excursus and therefore not empirical

research⁹ which brings into question the trustworthiness of applying a new theoretical framework to data onto existing research that is likely to deviate from the original aims and objectives of the research included (Rydeman et al. 2012).

Despite this, a biomedical focus eclipsing patient involvement or other individual focussed approaches was also discussed in a study into how American medical residents learnt about discharge planning in one hospital unit (Goldman et al. 2015). Here it was discussed that medical dominance in discharge decision-making rendered activities such as inter-professional meetings pointless and tokenistic as this medical dominance in decision-making existed regardless of the experience or seniority of the doctor (Goldman et al. 2015). In the case of Goldman et al. (2015) the research's sole focus was on the medical profession which may have skewed the findings related to processes like discharge which have multiple stakeholders. However findings are comparable with other studies of discharge planning (Atwal 2002; Rydeman et al. 2012). If teams and organisations withdrew from biomedical focus and medical dominance in discharge planning, it may be that discharge planning would better reflect policy intentions and experience may improve.

In contrast Dill's (1995) much older ethnographic study observed discharge planning to involve the debate and resolution of conflicts of interest between professional groups, rather than a single dominating point of view. For example, a social worker's assessment involving consideration of a person's psychosocial needs sometimes came into conflict with a medical assessment (Dill 1995). This was particularly true in the formation of expected discharge dates which required much debate and could lead to inter-professional frustration between medical and social work teams (Dill 1995). To overcome these frustrations Dill discusses how consensus on patient plans was needed. It may be that the lack of consensus is associated with a perceived medical dominance or lack of compromise but this is not reflected in Dill's analysis (Rydeman et al. 2012). However, Dill did identify some instances where consensus occurred. The more complex a patient's needs the more a collective opinion was needed and consensus was brought about through lengthy discussions and hearing every professionals' opinions (Dill 1995). Dill (1995) also observed that the most common way that families were involved in discharge was in the brief acknowledgement by health professionals that patients 'had supportive family' which translated as tacit knowledge that this case was 'unproblematic' and therefore did not require any further action. Families only became part of the process when they brought with them a problem (Dill 1995). In this instance, the family became part of the case. Dill (1995) therefore suggested that in

⁹ As it was not empirical research it did not strictly meet the inclusion criteria of this review. However in-keeping with the aim of gathering a critical overview the study was included as it was felt that the application of a new theoretical framework added useful and interesting insights.

order to understand the role of families in discharge, how health professionals construct families through the discharge process must also be understood.

These studies that used naturalistic methods confirmed some of the themes of aforementioned studies focussed on health professional, patient and relative experiences. However, these studies were able to build on these findings and further analyse the circumstances that created these experiences. As a result different approaches to discharge and approaches to the relationships that support discharge emerged. Reciprocal approach, individual approach, biomedical focus (incorporating medical dominance), client-centred practice and relational autonomy were all considered and discussed. The benefit of incorporating naturalistic data collection methods within further study on this topic therefore appears crucial to understand not only the experiences but the context that shapes these experiences and to analyse what, if anything, needs to change.

4.1.8 Summary of discharge planning for older people literature

This literature review set out to present a critical overview of the existing literature on discharge planning for older people, understand and explore what is meant by the term 'discharge planning' for older people, synthesise the current approaches to investigating discharge planning in the acute environment and ascertain any gaps in the existing knowledge.

Despite the wide variability in studies in this review, some conclusions about the knowledge base on discharge planning for older people can be drawn. Poor communication between inpatient and community teams was a widely documented barrier to the successful organisation of discharge plans (Bull & Roberts 2001; Coffey 2006; Connolly et al. 2009; Davis et al. 2012; Chapin et al. 2014; Cadogan et al. 2016). Poor communication internally in inpatient teams was also noted to be an issue (Bauer et al. 2009; Connolly et al. 2009). The fact that patients have increasingly complex needs was another issue that was discussed as a barrier to effective discharge planning (Bauer et al. 2009; Wong et al. 2011; Challis et al. 2013; Albrecht et al. 2014). It is acknowledged that this barrier occurs due to health organisations and systems not adapting to population need rather than placing any blame on the population generally.

Further problematic organisational systems, or in some cases a lack of clear discharge planning systems, were identified as a major barrier to discharge planning (Pethybridge 2004; Fisher et al. 2006; Davis et al. 2012; Cadogan et al. 2016). Additionally, staffing was a key system fault where there wasn't enough or staff weren't skilled enough in effective discharge planning (Connolly et al. 2010; Davis et al. 2012; Cadogan et al. 2016). A lack of community services to help bridge the gap from the hospital environment was also an issue consistently discussed (Bull & Roberts 2001; Connolly et al. 2009; Wong et al. 2011; Cadogan et al. 2016).

In terms of health professional roles it was discussed that nurses planned, organised, chased and badgered to ensure discharges were well organised (Atwal 2002; Watts & Gardner 2005). The pressure for staff to complete and organise swift discharges was also evident and this pressure was discussed as contributing to disillusionment and a reduced sense of professionalism (Connolly et al. 2009). In addition, health professionals were concerned that they were having to reduce and simplify the needs of patients to ensure that they better fit the system (Connolly et al. 2009).

Relatives' and carers' experiences were also established. Their role was often described as an advocate and organiser (Procter et al. 2001; Bauer et al. 2009; Popejoy 2011) but their involvement in the process appeared varied (Procter et al. 2001). Neiterman et al. (2015) discussed how carers involved in discharge were more likely to be women than men and that previous experience and knowledge about discharge helped them negotiate the process. Feigin et al. (1998) discussed the loss involved in being a carer or relative to an older person during the discharge process in terms of time, cost and privacy.

For the older people themselves, the discharge process was an experience of apprehension, anxiety and confusion (Fisher et al. 2006; Neiterman et al. 2015). They received poor information about their discharge which only added to this confusion and uncertainty (Tierney et al. 1993; Knight et al. 2013; Neiterman et al. 2015; Cadogan et al. 2016). Their participation in the process of discharge was generally low and those who were involved tended to have personality traits such as 'strong-willed', 'articulate' and 'confident' (Fisher et al. 2006).

Discharge planning interventions were shown to have limited effect, usually on organisational targets such as readmission rates or length of stay (Shepperd et al. 2010; Fox et al. 2013; Allen et al. 2014). The intervention studies lacked consistency on measurement and had difficulty in separating intervention groups from control as well as preventing cross contamination between groups.

Finally, Rydeman et al. (2012) discussed the discharge process for older people as one of embodied, contextual and existential 'in between'. A number of different approaches to discharge planning were identified but these theories lacked consistency amongst studies except the observation of medical dominance in discharge decision-making (Atwal et al. 2012; Rydeman et al. 2012; Goldman et al. 2015).

A number of different methods and methodologies were used. The studies with the most in-depth findings tended to be those which used a number of different methods and sources. As discharge planning is so difficult to measure, define and categorise, those studies with naturalistic aspects were able to add insight regarding the context of discharge planning. This is especially important

given how many of the findings were related to issues of systems and organisation. Additionally, as Bauer et al. (2009) reported some of the issues identified in much earlier research are still being reported in more recent studies, suggesting that current discharge planning is yet to reflect best practice. This is a finding that has also been clearly reflected within latest policy investigation (National Audit Office 2016). Further research needs to explore why this may be. The decision-making aspect of discharge has been touched upon by the studies in this review but not studied in depth.

4.2 Focussed narrative synthesis on older people's experience in discharge decision-making

So far this chapter has presented a critical overview of the literature relevant to discharge planning for older people in the acute hospital. Studies that have focussed specifically on the decision-making process for older people have been limited and largely they have focussed on the discharge planning process as a whole rather than the specific decision-making aspect.

In keeping with the policy agenda of involvement and shared decision-making as well as the necessity of understanding patient experiences, it was deemed necessary to focus specifically on older people's experiences of the discharge decision-making process in attempt to gain further clarity on this specific issue. A systematic search of the literature and narrative synthesis of the evidence has therefore been completed. This chapter describes the systematic search, synthesis process and findings of a narrative synthesis into older people's experiences of decision-making.

4.2.1 Narrative synthesis aim

The aim of this synthesis was to explore and synthesise what is currently known about older people's experiences of discharge decision-making in the acute hospital environment.

4.2.2 Narrative synthesis methodology

There are a number of recognised approaches to systematic qualitative synthesis. Popay et al. (2006) identified that the narrative synthesis approach is useful to bridge gaps between policy, research and practice. This method was therefore chosen to help establish if the policy rhetoric of involvement and shared decisions translates to older people's experiences. Narrative synthesis focusses on words and meaning within descriptive accounts and compares these across studies to draw conclusions (Fisher et al. 2006). As discovered in the previous critical overview of the literature on discharge planning, Fisher et al. (2006) used a narrative synthesis to understand

older people's general experiences of discharge and provided a working example which underpins the steps taken in this synthesis.

4.2.3 Systematic search strategy and inclusion criteria

A systematic search across a number of main databases was conducted. The individual searches and search terms used can be found in Table 2.

Search	Database	Search terms	Results	(N) included
1	CINAHL	Aged OR Frail Elderly OR Older People AND Transfer, Discharge OR Early patient discharge OR Discharge Planning AND Decision-making OR Decision-making, patient OR Decision-making, ethical OR Decision-making, clinical	145	8
2	MEDLINE	Frail Elderly OR Older People AND Patient Discharge AND Decision-making	10	3 (all duplicates)
3	EMBASE	Aging OR Elderly Care AND Hospital Discharge AND Decision-making	14 22	1 (duplicate)
4	Psych INFO	Geriatric Patients AND Hospital Discharge OR Facility Discharge AND Decision-making	8 13	5 (3 duplicates, 2 new)
5	AGEInfo	Older people OR Aged OR Elderly AND Discharge AND Decision-making	6	1
			Total:	11

Table 2 Search Strategy

In order to ensure all relevant articles were sought the search terms were mapped to the most relevant subject headings or keywords by which each database organised its articles. Therefore search terms varied from database to database. The title and abstracts of articles were initially reviewed and exported to EndNote reference manager to store if they met the inclusion criteria.

The inclusion criteria were as follows;

- The views of older people should be central to the study
- Studies should have sought face-to-face methods of data collection
- Studies should be concerned with patient's experiences of discharge from an acute hospital

It was felt that these inclusion criteria would ensure that qualitative methods of exploring older people's experiences were found. Searches were originally set to find studies published within the last ten years (2004-2014) to ensure that findings were applicable to the modern context of health care systems. Subsequent search re-runs were completed to ensure updates in the literature were captured. The most recent search, the results of which can be found in table 1 was completed in January 2018. The majority of the results of these searches did not meet the inclusion criteria. Largely this was because they did not seek to gain the experiences of older people or they were concerned with hospital transfers (from ward to ward) or discharges to care homes and not applicable to the aim of this synthesis.

4.2.4 Data extraction and synthesis

Each of the 11 articles was then read in full and assessed as to the strength of the article's correlation to the research question. The formulation of the criteria for strong or weak correlation was guided by Fisher et al's (2006) working example. This also entailed an assessment on the quality and rigor of the articles using the consolidated criteria for reporting qualitative research (Tong et al. 2007).

Articles were deemed to have a strong relation to the question if they had a focus on the views and experiences of older people in relation to hospital discharge and decision-making. Articles with a strong correlation evidenced in-depth analysis and provided a detailed account of the findings.

Articles were deemed to have a weak relation to the research question if they focussed on older people's experiences but did not have a specific focus on discharge decision-making in particular, for example they focussed on the whole discharge process more generally. In studies assessed to have weak correlation analysis may have lacked depth for example using oversimplified analysis frequency counts.

Articles were excluded at this point if there was a complete lack of exploration regarding discharge decision-making. Excluded articles yielded data only specific to the discharge experience or too specific to one context or time which had not been sufficiently described. Often, these excluded studies were included in the overview of literature provided in the first half of this

chapter. Additionally, articles were excluded if they were not accessible via the University's institutional journal access.

After this process, six articles remained in the study. Three were assessed as having a strong correlation to the research question and three were assessed as having a weak correlation. It was decided that they would all be included to allow for a broader synthesis. Table 2 provides more information about these included studies. Three studies were set in the UK and the remaining three were set in Australia, Sweden and Norway. They mostly used interview or conversations to collect data but other methods such as observations and questionnaires were sometimes used alongside.

Table 3: Studies included in narrative synthesis

Authors	Year	Article Title	Setting	Methods of data collection	Older people as participants	Strong or weak
Huby, Stewart, Tierney and Rogers	2004	Planning older people's discharge from acute hospital care: linking risk management and patient participation in decision-making.	General Hospital Scotland	Ward based observations and formal interviews with older people and hospital staff	N=22	Strong
Dyrstad, Laugaland and Storm	2015	An observational study of older patients' participation in hospital admission and discharge – exploring patient and next of kin perspectives.	Regional hospital Norway	Participant observations including short conversations	N=41	Strong
Roberts	2002	Exploring participation: older people on discharge from hospital.	General hospital UK	Questionnaires and interviews	N=260 for questionnaires and N=30 for interviews	Strong
Denson, Winefield and Beilby	2012	Discharge-planning for long-term care needs: the values and priorities of older people, their younger relatives and health professionals.	Australian City Hospital and Urban Medical Centre	Interviews	N=10	Weak
Ekdahl, Linderholm, Hellström,	2012	'Are decisions about discharge of elderly hospital	1 teaching hospital, 2 general	Observations and interviews	N=9	Weak

Andersson and Friedrichsen		patients mainly about freeing blocked beds?' A qualitative observational study	hospitals (urban and rural) Sweden			
Pearson, Procter, Wilcockson and Allgar	2003	The process of hospital discharge for medical patients: a model	1 teaching hospital, 2 general hospitals UK	Interviews	N=30	Weak
Durocher, Gibson and Rappolts	2017	Mediators of marginalisation in discharge planning with older adults	1 30 bedded rehabilitation facility in Canada	Observation and interview (including health professionals and family members)	N= 5	Weak

Following the data extraction process, the articles were uploaded onto NVivo software and a thematic analysis approach was used to draw together themes for the synthesis. Thematic analysis has been identified as a useful approach in narrative synthesis to identify the most significant as well as recurrent themes (Popay et al. 2006). It also enabled an inductive approach to theme development. Thematic analysis involves reading through the data in order to become familiar with it, initial coding of the data, drawing these codes into overarching themes, reviewing the themes, defining them and then producing a report (Braun & Clarke 2006).

4.2.5 Narrative synthesis critical appraisal

The critical appraisal conducted as part of this synthesis raised the following issues. Only three of the studies included in this synthesis were based in the NHS healthcare system (including NHS Scotland). Although some other health care systems are publicly funded and therefore similar to the NHS, the patients' culture as well as that of the organisation is likely to be different, limiting how transferrable the findings of these studies are to the English NHS context of focus in this thesis.

Some other transferability issues were also identified. The study by Huby et al. (2004) used two case studies as a vehicle for presenting the findings from their pilot study and acknowledged that both cases were female patients from similar socio-economic backgrounds with similar levels of support which therefore limits any potential transferability. Additionally Pearson et al. (2004)'s data were collected in the late 1990s, almost 20 years ago and therefore due to political and economic changes may not now be as relevant to the current context of discharges.

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Some articles included in this synthesis represented only part of the findings from larger projects. This meant that these articles could lack depth in the information provided on recruitment techniques and data collection strategies (Huby et al. 2004; Pearson et al. 2004). The article by Durocher et al. (2017) also presents the same study as Durocher et al. (2015) which was reviewed in the first half of this chapter. Although this means that new findings are not necessarily introduced, the first publication focusses on client-centred practice in discharge planning whereas the recent publication provides a more in-depth analysis on decision-making, hence the inclusion in this synthesis. Papers reporting mixed methods studies often lacked depth on their qualitative data analysis techniques and the impact of the researcher on the findings (Roberts 2002; Denson et al. 2012; Durocher et al. 2017). This could be a publication bias due to the word constraints of reporting large studies for publication. But, Roberts (2002) for example, referred to their qualitative data analysis as “analytic categories” and provided no further information on the development of these categories. A lack of information is arguably detrimental to the extent to which these qualitative findings are dependable. Despite this, the synthesis of these studies has provided useful and important insights into older people’s experiences of discharge decision-making.

4.2.6 Narrative synthesis findings

The findings were split across four themes. These themes were; ‘no role for older people,’ ‘older people unable to voice their preference’, ‘older people relying on relatives’ and ‘factors that affected decision-making’.

4.2.6.1 No role for older people in discharge decision-making

Generally there was no patient role or involvement identified in discharge decision-making (Ekdahl et al. 2012; Dyrstad et al. 2015). It was discussed that older people did not expect to have a role in discharge decision-making nor did they expect to be listened to if their preference was different to the outcome of the decision (Ekdahl et al. 2012). They reported that being involved was not important to them and they were comfortable for decisions to be made by professionals even without their consultation (Roberts 2002; Dyrstad et al. 2015). Ekdahl et al. (2012) identified one participant who said “thank you” to the health professionals who made the discharge decision despite not agreeing with them. When patients did disagree it was mostly because they felt they needed more time to feel better or to feel able to manage once home (Dyrstad et al. 2015). As a result, discharge was often difficult to comprehend especially when the environment was pace focussed as patients were not able to adjust to how quickly the decisions were made (Ekdahl et al. 2012).

Participants felt that even if they'd wanted to, they wouldn't be able to influence decisions about discharge, *"I don't think you can influence decisions and that's just as well"* (Ek Dahl et al. 2012 p.5). Plus, it was considered that *'it wouldn't be right'* for older people to contribute to their discharge decisions as this is the role for health professionals (Huby et al. 2004). Roberts (2002) reported that all of the participants in her study felt they needed to wait for permission from health professionals in order to be discharged. There was also the feeling that adult children and health professionals just "knew better" than patients in terms of what "was right" for their discharge plans (Durocher et al. 2017). Moreover, patients reported to the researchers that they wanted to stay longer than they were allowed but didn't or couldn't communicate this to the health professionals (Ek Dahl et al. 2012).

4.2.6.2 Unable to voice a preference

Often participants were rendered voiceless in discharge decision-making, their preferences were either not asked or not listened to (Huby et al. 2004; Ek Dahl et al. 2012). In those instances, having a preference or being willing to take part in decision-making was pointless. Some older people reported feeling too unwell to participate in decision-making (Ek Dahl et al. 2012). No explicit effort to engage with or encourage participation for those who did not feel able was reported. On the rare occasions when people did take a more active role in discharge decision-making they reported feeling well and ready to go (Roberts 2002). These patients were more likely to start thinking about discharge unprompted as well as ask about it. It is important to note that although a lack of involvement was consistently reported, older people did report a range of involvement preferences for their care transitions (Dyrstad et al. 2015). It therefore cannot be assumed that being voiceless in decision-making is the preference of all older adults. When given a choice of involvement preferences, older people were able to use their voice to decide.

Conversely, one study identified a standard practice that health professionals determined as "the opportunity for older people to be involved" in the form of discharge planning family conferences (Durocher et al. 2017). However even within these meetings with the sole purpose of engaging with older people, a lack of patient voice was maintained. The meetings took place with health professionals on one side, patients on the other and often family members behind them. The language of the meetings was consistently in terms health professionals would use on a daily basis. Despite appearing engaged (nodding along, smiling) patient experience did not indicate that they felt involved – rather marginalised by the formal organisation of these meetings as well as the language used (Durocher et al. 2017).

4.2.6.3 Relying on relatives

Particularly clear across the synthesis was the extent to which older people relied upon their relatives. Similarly to findings in literature on discharge planning more generally (see 4.1.5.2) relatives became advocates for older people in the discharge decision-making process (Roberts 2002; Pearson et al. 2004; Dyrstad et al. 2015; Durocher et al. 2017). In some instances, relatives were a voice to the voiceless; *“my daughter can be my voice, which is vital to me”* (Dyrstad et al. 2015 p.1702). They liaised with the professionals (Roberts 2002) and provided extra support and reassurance (Pearson et al. 2004). Relatives were integral in negotiating a discharge decision and a discharge process that was acceptable for patients.

4.2.6.4 Factors affecting discharge decision-making for older people

The synthesis showed that not only was a patient’s ability to participate in their discharge affected by how they felt in hospital, how able they felt to communicate their needs and their trust in health professionals.

Participants found communicating their symptoms, feelings and decisions difficult (Ek Dahl et al. 2012; Dyrstad et al. 2015). It was also evident that the discharge information they were given was often too complex for ease of understanding and people generally did not deem themselves to be knowledgeable enough to make decisions about their discharge (Ek Dahl et al. 2012; Dyrstad et al. 2015). In particular, the medical language used in discharge papers and discharge meetings was difficult for patients to understand and thus excluded them from having an impact on the decision-making process (Dyrstad et al. 2015; Durocher et al. 2017). Those who had been in hospital before had an advantage as they had become used to and more aware of the routines and systems (Dyrstad et al. 2015). The advantage of having previous experience of hospital and health systems was also a finding within the literature on discharge planning generally (Fisher et al. 2006).

Patient participants had unwavering confidence and trust in the professionals (Dyrstad et al. 2015). Health professionals’ use of medical language, for example, although not generally understood by participants in the included studies added to the level of dependence that patient’s had on health professionals to make decisions for them. This led to statements such as *‘they’re the expert’* and *‘they know best’* which deposed the need for patient participants to be involved their own discharge decision-making (Roberts 2002). Not only were older people feeling that they were not able to influence discharge decisions, they also did not feel qualified enough to have an opinion and that their opinion did not warrant being listened to. In Ek Dahl et al.’s (2012 p.6) study one participant reported *‘it’s enough just to hope that they take the right decision’*. It

was evident that participants trusted health professionals to make decisions on their behalf because they saw that to be an accepted part of health professional's job and not the job of patients (Roberts 2002; Huby et al. 2004). Within this implicit trust, health professionals' pre-occupation with patient safety meant that any thoughts and feelings voiced by patients were overridden anyway and this appeared to be an expected and accepted outcome (Durocher et al. 2017).

4.2.7 Summary of narrative synthesis

This synthesis showed that older people have no role in the decisions about their discharge. Discharge decision-making was a process that they were excluded from, even when effort was made to engage them, as they could not understand the process, the language used and the information that hadn't been tailored to their needs. This exclusion from the process manifested itself as an 'embodied trust' in health professionals to take full responsibility in decision-making resembling the 'paternalism' that is no longer accepted as best practice in healthcare. Despite older people not describing any concerns in the way discharge decisions were made in hospital, it is unclear whether their experiences were in accordance with their preferences.

Trust in health care professionals is often discussed using sociological theory as contradictory to the policy agenda of increased patient participation in health care decision-making (Calnan & Rowe 2007). Trust is more associated with the traditional patient role of passivity and a '*blind trust*' in clinicians which was evident in this synthesis (Calnan & Rowe 2007). In fact, there is no doubt that the experiences of discharge decision-making presented in this synthesis fall entirely in the category of '*embodied trust*'. This is set within a paternalistic context of medicine within a '*traditional*' patient to clinician relationship. The alternative level of trust, more aligned to the policy message of shared decision-making would involve 'informed trust' in a more modern patient to clinician relationship (Calnan & Rowe 2007).

Just as Weicht (2010) discussed how the current push towards shared decision-making and involvement resulted in further demonization of dependency (as reported in section 2.2.12.3), Calnan and Rowe (2007) argue that it also facilitates an increased interdependence between professionals and patients rather than any form of patient empowerment. The increased responsibility coupled with vulnerability encourages passivity and a drive to delegate the responsibility elsewhere.

In this synthesis, the opportunity to empower patients in the acute care environment by assuming them to be expert in their own experiences is missed. This could be due the tendency for older people's conditions or symptoms to be fragmented to medical specialties or because time

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constraints mean that patients' own knowledge and interpretation cannot be assessed. Only one of the included studies detailed a specific meeting, in the presence of patients, where discharge decisions were made and a discharge was planned. Even in this case, older people were unable to influence the course of discharge decision-making as decisions were driven by health professional's agenda of safety over patient preference.

Older people's experiences reported in this synthesis of a lack of influence and not being heard are not uncommon of experiences reported of acute care more generally for older people (Bridges et al. 2010). These findings provide no evidence that policy for shared decision-making, involvement and more empowering healthcare systems for patients have impacted on the actual experiences of older people. The similarities in findings with this review and Joseph-Williams et al.'s (2014) synthesis that focussed on shared decision-making for all healthcare decisions for older people (see section 3.5) show that similar issues bridge across all healthcare decisions for older people; environment, terminology and trust.

In conclusion, this synthesis highlights the gap between the policy message of involvement and the current experiences of older people having no role in discharge decision-making. The findings in this synthesis are comparable and confirmable with reports of wider acute care experiences, discharge planning experiences and other care decision-making for older people. Although all of the studies included in this synthesis are based in inpatient hospital wards, none of them explored discharge decision-making within the specific context of a short stay environment. Within the current movement towards shorter acute hospital stays in the English NHS, experiences in these contexts are specifically useful and necessary before improvements can be sought. The impact of an AMU context on involvement or shared decision-making for older people needs to be explored and better understood.

4.3 Chapter Summary

Within this chapter a critical overview of the research on discharge planning for older people was presented. This identified issues of communication, lack of community services and poor discharge planning systems to be some of the barriers to good discharge planning. It identified poor experiences of discharge planning for older people, health professionals and relatives. It was not possible to conclude whether any existing intervention to improve discharge planning would be effective at improving length of stay, readmission rates and patient experience. Discharge planning interventions are difficult to measure as they are difficult to define and separate from usual care. In addition the discharge planning process should be both context and individual specific. The overview of the literature also identified that, because of the context-specific nature

of discharge planning and its' outcomes, some of the most insightful studies were those that used multi-methods, involved a number of stakeholders and had a naturalistic approach to data collection. Following this, an in-depth exploration and synthesis into older person's discharge decision-making specifically unveiled some novel findings relating to trust in health professionals and the impact of older peoples' health literacy on their perceived ability to contribute to decision-making.

One author utilised a bioethical, relational autonomy theoretical lens to investigate discharge planning and decision-making and concluded that taking an approach to care underpinned by relational autonomy may enable better experiences and outcomes (Durocher et al. 2015; Durocher et al. 2017). Relational approaches to care have been suggested previously as ways to ensure that patients are valued as both individuals and as patients in the healthcare environment (Williams et al. 2009; Bridges et al. 2010; Maben et al. 2012). The use of relational interpretations of autonomy builds on this specifically for discharge decision-making and also reflect the aims of policy calls for shared decision-making and the relationships required to achieve this.

The findings of this chapter identify a need for an in-depth exploration into the phenomenon of discharge decision-making for older people in clinical practice. There remains a disparity between professional and policy recommendations and the current discharge planning experience. There is a lack of consensus in unpicking why this may be, but a number potential factors identified as having an impact include pace, trust, healthcare organisation and individual factors associated with older people such as experience in the system and decision-making preference. Future research should seek to understand the phenomenon from the perspectives of all those involved with a naturalistic element that will allow for the context within which the discharges are planned to be well understood. There is a large gap in the literature for the exploration of aspects of discharge planning for older people in short stay and high acuity environments such as an AMU. This gap in the literature is not representative of the high use of AMUs in the English NHS (Scott et al. 2009).

This section concludes the background to the study reported in this thesis. The next chapters will explore the study's methodology, findings, discussions and recommendations. In doing so, it will return to the research findings, concepts and theories that have been introduced in these early chapters.

Chapter 5: Methodology and methods

5.1 Introduction

The phenomenon for inquiry in this study is discharge decision-making for older people. This study is framed within a subtle realist philosophical position enabling an inquiry that prioritises an in-depth understanding and representation of the views, experiences and life worlds of all those involved (Hammersley 2002). Improvements in practice and patient experience need to be built on the foundation of a comprehensive understanding of the context, culture and behaviours surrounding a phenomenon (Savage 2000). The previous review of the literature identified that a methodology that used multi-methods, sources and a naturalistic component added useful insights on the complex process of discharge planning. Focussing on the intricacies of current practices as they occur naturally can inform intervention, change and future research that is feasible and relevant. Future changes need to be embedded in contextual understanding to be successful and an inquiry in a naturalistic setting facilitates that.

An ethnographic approach was selected for this study to explore the process by which discharge decisions are made for older people. This chapter introduces the ethnographic approach and provides justification for its use in this study. The researcher's positionality, beliefs, values, ontology and epistemology within which the research is interpreted are introduced to ensure that reflexivity is embedded within the reporting and analysis of this project. The research processes completed including data collection, analysis, ethical considerations and patient and public involvement activity are then discussed in detail. Throughout the chapter, to ensure reflexivity and openness certain sections are written in italics indicating a reflective style.

5.2 Research aims & objectives

Aim: To describe and explain the processes by which discharge decisions are made for older people returning to the community from an acute medical unit.

Objectives:

1. To understand the context within which discharge decisions are made
2. To explore the impact of the context of the AMU on those involved in discharge decision-making (patients, staff and relatives).
3. To explore the impact of the AMU context on discharge decision-making and identify the characteristics of the process of discharge decision-making in this context

4. To describe the impact of discharge decision-making practices on all those involved in the process (patients, staff and relatives).

5.3 Summary of the data set

Full detail of the methods used within this study will be described as this chapter progresses. In total, 12 interviews were undertaken with older people and nine with older people's relatives. Two group interviews were conducted with a total of seven participants. Approximately 54 hours of observation was undertaken across 2 research phases. Seventeen nursing handovers were observed in addition in the first phase. Documentary evidence was also collected including five extracts of patient notes, two leaflets for patients and three standard assessment forms or checklists.

5.4 The ethnographic approach

This study uses an ethnographic approach using a number of methods to understand the phenomena, context, environment and culture related to the aims and objectives of this study. Ethnography is focussed on social inquiry in its natural context and has had great impact in the fields of anthropology and social sciences (Hammersley & Atkinson 2007; Murchison 2009). Ethnography helps to disentangle and better understand complex healthcare systems and environments by using multi-methods to focus on aspects of care that are hard to measure and multi-faceted (Savage 2006). As the perceived importance and significance of patients' opinions on NHS services continues to expand, the value of ethnography to inform improvements is increasingly being recognised (Savage 2000).

Hammersley and Atkinson (2007 p.3) highlight some commonalities in ethnographic research;

- People's actions and accounts studied in everyday contexts
- Data gathered from a range of sources
- A relatively unstructured approach to data collection and analysis that is not confined to pre-determined categories but drawn from the data itself
- Fairly small-scale focus such as a single setting or group of people to enable in-depth exploration

- Analysis of data involving interpretation of the meanings, functions and consequences of human actions and institutional practices and how these are implicated in local, and also wider, contexts.

This ethnographic research is foreshadowed by the disconnection between policy recommendations and current experiences as detailed in the previous chapters of this thesis. Ethnography is an ideal approach to understand discharge decision-making for older people on the AMU as it allows a broad view of environment, context and culture alongside a focus on individuals. It attributes a meaning to individual experiences and actions in the naturalistic environment (Hammersley & Atkinson 2007).

Ethnographers are fundamentally students of culture (Van Maanen 2011). In healthcare organisations recommendation of culture change in order to provide better quality, more efficient or cost-effective care are often made (Scott et al. 2003). The culture of the NHS, is more regularly referred to as an organisational culture. Generally definitions are consistent that organisational culture is what is shared within an organisation; the ideals, beliefs, attitudes, values and behavioural norms (Dixon-Woods et al. 2014). Some argue that it is not possible to define the term culture as it is specific to a context and therefore requires exploration in contextual situations for theory development rather than definition to occur (Goldstein 1957). Therefore as this ethnographic study progressed field notes reflected observations made of what Dixon-Woods et al. (2014) describes as the shared norms of organisational culture.

5.4.1 Reflexivity

Ethnographies that do not attend to the social processes of the ethnographers that shape the fieldwork and the findings can be heavily criticised (Brewer 2000). The idea that ethnographers are able to represent social reality, isolated by their own influence, just by becoming close to it has widely been rejected (Hammersley & Atkinson 2007). Instead, there has been a trend in social research towards reflexivity. Reflexivity requires researchers to be explicit about the circumstances which produced their data whilst acknowledging their presence within the social world they analyse. A reflexive ethnographer seeks to understand the contingencies that produced their portrayal of themselves, of events and of findings (Brewer 2000). The importance of reflexivity in ethnographic research is heightened as the relationship between the researcher and the researched tends to be more long term, intimate and complex than some other approaches (Davies 2008). Additionally the disciplinary and sociocultural circumstances under which fieldworkers operate have a profound effect on the way fieldwork is conducted (Davies 2008). Reflexivity not only serves to set the scene for how the research was conducted, it also

reveals the researchers' awareness of their necessary connection to the research and their effect upon it (Davies 2008). In order to achieve reflexivity, the researcher must be clear about their background, positionality, role in the field and behaviours (Brewer 2000; Hammersley & Atkinson 2007).

5.5 Researcher positionality

A clear understanding of researcher positionality ensures that findings can be understood not only in the context of the field but also in the context of the social world in which the researcher is an actor. Research and research processes are personal, emotional, sensitive and therefore need to be situated within existing cultural and societal constructs shaped by the researchers identity (Coffey 1999). Therefore, the positionality statement below is provided at this stage, before specific methods are explained, to provide full disclosure and allow the reader to interpret the research plans, findings, ethics and discussions with the knowledge of who the researcher is. Following this, the profession of the researcher is described and related from a philosophical standpoint to the methodology used in this study.

5.5.1 Positionality statement

I am a white, unmarried, female in my early to mid-twenties. I am a qualified occupational therapist who throughout the duration of this PhD project was on a funded pathway that involved a part time clinical role alongside the part time completion of a PhD. My studentship was funded by one of the community Trusts that served the same population as the acute hospital where my research is set. I worked clinically in a team in the acute hospital for the first three years of my studentship. The acute hospital was run by an acute hospital Trust, different to the one providing studentship funding. Throughout my studentship, my occupational therapy team was funded by the same Trust that funded my studentship, as part of an agreement with the acute hospital Trust. During the first phase of data collection I was collecting data and working clinically in the same hospital but in different clinical or ward areas. I worked in various clinical departments including outpatient hand therapy (trauma and rheumatology), trauma and orthopaedic inpatient wards (mainly seeing older people with fractured limbs) and the medical team (caring for those with medical needs in a number of different specialties including oncology, respiratory medicine, medicine for older people, renal medicine and cardiology). This meant I had met a number of people working at the hospital in a professional capacity, however I never worked on the AMU. This was largely because

there was no occupational therapy provision along the acute and urgent care pathway at this time (Emergency Department, Observation Unit or AMU).

Working clinically I discovered that there was a subtext of negativity regarding the AMU amongst my clinical team. Historically, the medical occupational therapy team had provided therapy services for patients along the acute pathway. However, years before I joined the Trust and commenced my studentship, the funding for the acute therapy service had been withdrawn and re-allocated to a community team that would provide intermediate care funded by a different community Trust. During my studentship, therapy provision in the acute pathway was however changing. By the time my data collection phases had commenced a permanent Physiotherapy service had been re-established.

Some of my Occupational Therapy colleagues felt very dissatisfied with the AMU arrangement and had felt personally offended by how the decision to withdraw the funding for AMU Occupational Therapy had been made all those years ago. During my work, these conversations in clinical practice were unavoidable. I was however very conscious of this and actively decided not to pass any opinion on the historic events nor let it shape the course and aims of my research. Some colleagues assumed that the aim of my research would be to prove that Occupational Therapy was needed in the AMU. This weight of expectation led me to repeatedly make sure to clarify that the aim of my research was broader than one profession and shaped by policy and literature.

One further downside of these historic events was that I felt that there could be some animosity with the staff on the AMU if I strongly associated with my profession and the Occupational Therapy teams that I was a part of. I therefore took the stance of not concealing but not overtly revealing my clinical role. I did not withhold the information, as it was written repeatedly in my study information, but I was focussed on not bringing my clinical identity to the forefront of my time as a researcher on the AMU.

I am not local to the area where the hospital is based. I grew up in a different county altogether and during my studentship I was living in a neighbouring city. As part of being a qualified Occupational Therapist I have a degree in Occupational Therapy. I am educated and fairly well spoken. Patients and colleagues from the hospital would often describe me as 'posh' and seemed to position me that way when they discussed their own education and social circumstance.

Before the fieldwork commenced I'd worked for two years in the hospital. I'd developed a good working knowledge of the surrounding area having visited a number of patients' properties as part of my clinical role and had many conversations with patients about the places they lived and the places they visited. Despite this clinical role, I never encountered any patient I'd worked with throughout my fieldwork.

My clinical role in the acute hospital as an Occupational Therapist was largely associated with discharge planning. It involved functional assessments, environmental assessments, cognitive assessments, rehabilitation, education, close liaison with patients and family members, liaison and joint working with other professions, providing equipment, facilitating discussions on discharge planning, managing expectations and supporting patients as they often prepared for an altered version of reality at home. As such, I was very aware of the community services and teams available to assist in this transition.

At the end of the studentship, I left the South Coast and moved to London to commence a full time role as a Specialist Occupational Therapist in older people's care. The majority of the data analysis for this project had been completed by then, but it had not been written up. The experience of a new clinical role may well have impacted my analysis and reporting slightly as I have another environment, location and group of services to compare with the one in focus here. However, I did not actively seek comparison as I was writing up. Any influence of my current place of work should be incidental. In my current role, I continue to be involved in the discharge planning of older people but this time in a different geographical location.

5.5.2 Values and Beliefs

I hold the philosophy that society should be fair and should treat every individual equitably. Also relevant to this research is my view that old age is a privilege, both to the individual and to society. I reject any philosophy that old age is burdensome or that it is inevitably miserable, isolated and lonely. But I do accept that some older people do feel burdensome, miserable, isolated and lonely. Personally, I am optimistic about growing old but I do understand that others may view this as naïve and that societal changes may be needed to ensure aging is a positive experience for all. In terms of discharge planning, I believe that patients should be discharged with an arrangement that suits their wishes, preferences and in a way that encourages them to maintain independence and keeps their life-world as broad as it was before. I dislike discharge planning that may confine a person to a bedroom or to their flat for a long length of time without sufficient support

or long term planning and feel these kinds of discharges have negative impacts on a person's health, dignity and human rights. I also appreciate that home is not always the best or most preferential destination but that decisions such as these should be made with multidisciplinary assessment and with families and patients having time and information to enable them to make informed decisions. I believe patients, alongside their relatives, should be supported to make all decisions regarding their discharge and be provided with as much information as is possible about their options as well as multidisciplinary assessments and recommendations. I feel that this can be achieved in acute hospital environments. I believe that short length of stays are often good for patients' health and wellbeing but that on occasion the needs of an individual may require a longer stay for reasons more than just medical (for example rehabilitation or respite).

5.5.3 Occupational therapist and fieldworker; managing being a clinician

Occupational therapy '*provides practical support to enable people to facilitate recovery and overcome any barriers that prevent them from doing the activities (occupations) that matter to them*' (College of Occupational Therapists 2016). Occupational therapy aims to, "*increase people's independence and satisfaction in all aspects of life*" (College of Occupational Therapists 2016). Occupational Therapy is a profession that belongs to the group of professions called 'Allied health professions' regulated by the Health and Care Professions Council (HCPC).

Occupational Therapy is distinct in the fact that practice is focussed on enabling occupation, engagement, participation and performance (Wilding 2010; Drolet 2014). In that sense, despite the focus on 'independence' as an end goal, Occupational Therapy does not fully subscribe to the 'independence ideal' of Western culture as described in section 2.2.2 of this thesis. In practice, achieving independence in Occupational Therapy practice may involve adaptation, education and extra support from individuals or equipment. Occupational Therapy works within an alternative model to the medical model by bridging typical medical specialties and remaining focussed on the individual as a whole. Occupational Therapists are trained in both physical and mental health and are considered 'at the professional fault line' between health and social care (Blair & Robertson 2005). Despite this, job roles for Occupational Therapists often mirror medical specialties as well as health and social care organisational boundaries.

Like Nursing, Occupational Therapy relies heavily on the use of observation to form a large proportion of their assessments. For Occupational Therapists, these observations include observing movement, mood, interactions (with the environment and with the social actors within

the environment), activity, environment and communication. Things such as a simple movement from sitting in a chair to standing is observed in the context of the person's surroundings, wishes, preferences and social relationships. There are significant parallels and overlaps with ethnographic observations, to the extent that one author has recommended that all Occupational Therapy assessment and observation should be constructed as ethnographic observation to ensure observers develop an integrated picture of a client's functioning (Spencer et al. 1993). An Occupational Therapist should therefore be adequately equipped with the skills on which to base fieldwork observations that capture the multiple factors that may influence a moment in time. One large adjustment however is the way these observations are recorded. Although reflexivity is employed throughout therapy practice, documentation of clinical observations tends to be matter of fact and objective, contrary to what may be expected of field notes that begin to analyse a field.

Sometimes (for reasons explained in the positionality statement, see section 5.5) I chose not to be explicit about my profession to ensure that it didn't influence the way participants carried out their work or alter their openness. Sometimes however, using the occupational narrative of knowing how it feels to work in the hospital was required. Some field relationships appeared to require this elevated level of empathy in order to progress. My profession did not feature much in the discussions I had with most people in the field. Except for one instance where the consultant I job-shadowed talked to me about it lots and even introduced me in the field as "one of our OTs". This was more associated with the consultant's own agenda, but in this relationship the identity of Occupational Therapist was helpful in gaining access and maintaining that field relationship. This was often re-negotiated according to each field relationship and circumstance.

Anspach and Mizrachi (2006) discuss the conflict between managing the researcher's knowledge and expertise versus limiting their influence on the field. They argue that occasions arise where withholding information or refusing to give advice could create real and avoidable harm (Anspach & Mizrachi 2006). Advice giving could incur the risk of Hawthorne effects or the researcher producing the findings that they purport to describe, hence why researchers should be cautious about intervening (Anspach & Mizrachi 2006). Goodwin et al. (2003) reflected how in their ethnography, field actors' knowledge that the researcher was a nurse, placed the researcher in 'ethically uncertain territory' by the way they related to her and their expectations of her. To try to avoid this in this study the role that the researcher undertook as researcher was made clear throughout, "think of me as non-clinical" and "I'll just be watching what's going on".

Out of the field, after the interviews in patient's home, occasionally advice was given on falls prevention or signposting was provided to their GP for pain management or other services such as

social services or community Physiotherapy if a need had been identified whilst the interview took place. As the participants were no longer in a place where they were being looked after, it was responsible for the researcher to provide advice once those issues had been identified.

5.5.4 Ontology and epistemology

As a profession, Occupational Therapy is underpinned by an ontology concerned with values, perceptions and existential questions regarding doing and being (Blair & Robertson 2005). Occupational Therapy is theoretically eclectic and epistemologically pluralistic (Blair & Robertson 2005). As with many of the health and social care professions, Occupational Therapy uses a number of epistemologies to understand different aspects of knowledge to inform practice. To understand the science of practice, evidence based practice is adopted. To understand the art of practice, reflective practice is adopted and in understanding the social construction of practice, reflexive practice is adopted (Blair & Robertson 2005). This research however, although carried out by an Occupational Therapist, is not directly related to Occupational Therapy practice in particular rather healthcare practice in general.

Social research is interpreted within the parameters of a predetermined paradigm formulated by the researcher's ontology, epistemology and chosen methodology (Denzin & Lincoln 2013). Ontology refers to assumptions made on the nature of reality, epistemology refers to what can be known about the reality and the relationship between those who know and those who do not know and methodology refers to how what can be known becomes known (Guba & Lincoln 1994). There has been much debate on the philosophical approaches associated with qualitative research, the differences between qualitative and quantitative research as well as the relative importance of determining a specific philosophical direction for research.

Constructivism is considered a suitable paradigm for research with similar aims and objectives to this project (Simons 2009; Denzin & Lincoln 2013). A constructivist paradigm is founded on the ontological belief of relativism and the epistemological belief of subjectivism (Guba & Lincoln 1994). Ontological relativism refers to the understanding that constructions are situational, contextual and more or less informed rather than true or untrue and transactional epistemology refers to findings being developed interactively between the researcher and the researched (Guba & Lincoln 1994). However, constructivism is seen as controversial in social sciences as it rejects any reality except our constructions of it (Altheide & Johnson 2013).

Realism differs to constructivism because it is commensurable and does not adopt the ontology of relativism (Perry 1998). Hammersley (2002) proposed that although adopted by some ethnographers relativist epistemology poses a problem for ethnography. The idea that knowledge

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is culturally relative allows the prospect that, from a different culture's perspective, knowledge can be false causing barriers between cultures to be drawn which are also relative and therefore potentially false (Hammersley 2002). Hammersley (2002) is concerned that if researchers produce just one version of reality among several versions it negates the use for producing ethnography. He therefore adopts a subtle version of realism. He argues that subtle realism assumes the notion that knowledge (or the claim of knowledge as correct knowledge cannot be certain) does not change because the researcher has made the claim (Hammersley 2002). That a claim of knowledge is made on the basis that one is relatively certain the claim is valid (Hammersley 2002).

“For the most part, reality is independent of the claims that social researchers make about it”

(Hammersley 2002 p.74)

Subtle realism therefore acknowledges that understanding a knowable phenomenon relies on cultural assumptions and representing a phenomenon, not reproducing it, whilst assuming that knowledge is never certain (Hammersley 2002).

There have been many other versions on a theme of realism 'lite'; ethnographic realism, natural realism, critical realism, emergent realism and analytic realism (Altheide & Johnson 2013). All respond to the controversy of constructivism, but do accept some form of epistemological constructionism and relativity to an extent (Altheide & Johnson 2013). Subtle realism allows comparison of different perspectives gained on a phenomenon from different methodologies, with modification specific to the different goals that research approaches may have (Mays & Pope 2000). This is particularly useful in health services research that, as observed during the introductory chapters of this thesis, can vary theoretically, epistemologically and methodologically.

5.5.5 Methodology and positionality in summary

In summary, the researcher's positionality as young, student, female, subtle realist, occupational therapist shapes how she is perceived in the field, how fieldwork is completed, interpreted and how field relationships unfold. Acknowledging these factors allows further understanding of the ways in which fieldwork was configured. Maintaining this reflexivity, addresses potential biases and “distance” that these factors may create, it adds to the credibility of findings and embellishes the context to their interpretation (Mays & Pope 2000).

5.6 Fieldwork and methods of data collection

Here, the data collection methods are described. The fieldwork took place over of two phases, one focussed on patients and one focussed on clinical practice. This was indicative of the emergent nature of ethnographic research and meant that the researcher was not overwhelmed with trying to capture everything from every perspective all at once. This section starts by detailing the patient and public involvement activities completed prior to the research commencing. The field and how access was negotiated is explained and then the two research phases are described. Finally, the data analysis activities are illustrated culminating in the considerations made to ensure quality in the research and analysis processes. Throughout this chapter, italics are used for researcher reflections.

5.6.1 Consultation with patients and the public

This project uses INVOLVE (2015)'s definition of patient and public involvement in research; when research is carried out with or by members of the public by either contributing to, commenting on or carrying out a research project. The following sections are reflections of a group session that aimed to consult patients and the public about this research. It is acknowledged that the benefits of this style of consultation are limited as it had a pre-set agenda and was a one off consultation. In addition, the attendees of the meeting may not fully represent potential study participants as they are healthy, independent and socially active older people. I was not able to provide reimbursement to the participants of the consultation group for their time.

In this project the Health and Wellbeing Development Officer of a local branch of Age UK was contacted about creating an advisory group of Age UK members. I attended an Age UK social lunch group to discuss the research protocol, patient information sheets and consent forms. All Age UK lunch group attendees were older people aged 65 and over who visited the Age UK lunch club as a way of socialising with local peers. During the meeting I outlined the project protocol to all attendees and handed out example print outs of the consent forms and information sheets. After lunch, I visited each table of five members to discuss what they had read. Approximately half of the lunch club attendees took an active role in discussing the project with the remaining attendees reporting that they were not interested in the topic. A number of issues were raised.

Many attendees felt that they were unable to predict how they would react to being invited to the join the study if they were in hospital as they had little experience of what being a patient in hospital would involve. They felt that a large booklet of information to read would put them off participating and that they would be more likely to read a summary information sheet on one side of A4. Attendees expressed concern that participants may use the research interview as an

opportunity to criticise the NHS and that it may not be productive nor useful to the study. Some attendees advised that I should highlight that the research will help me complete my course as they felt helping me would motivate people to participate more. There were mixed views on participation, some reported they would only want to talk to someone who was going to help them get better, whereas others reported that they would relish an opportunity for distraction. They also identified that some individuals are more likely to participate if they have a previous affiliation with the NHS, for example, those who have worked in health and social care.

Attendees raised concerns about some of the terminology used in the participant information and consent forms. Specifically the use of 'PhD project' was rejected as they felt many would not understand it. Instead they determined that 'research project' or 'research degree' would be better. A notable concern for the attendees was the privacy of their personal information. Therefore they felt that it should be clear that I would not have access to participants' historical medical records. They suggested that the 'only relevant parts of medical records' sentence in the information sheet and consent form should be in bold for clarity. All attendees felt that it was imperative that older people's relatives were included in the study as they had personal experience of the vital role of being a relative in hospital.

The group lead to some key changes in the consent forms and information sheet. It also confirmed that using a summary information sheet would help to improve recruitment in the field. The fact that providing opinions was sometimes synonymously used by members of the group as being critical was interesting and was considered when the research was explained to participants. This exercise also prepared me for potentially low levels of recruitment in the project as many group members felt they'd be unlikely to participate if they were in hospital.

5.6.2 The field

The selection of a site is of utmost importance in ethnography as the context provides the backdrop for the phenomenon that is being explored (Hammersley & Atkinson 2007). Therefore, it should be ensured that the site is an optimum context for the phenomenon to occur. In this case, the site was already selected by the funders of the project. The site is an exemplar of a short stay environment where the discharge of older people is frequently facilitated.

The site is an AMU that sits within a large teaching hospital in the South of England. The unit has 58 beds and aims for a length of stay of approximately 48 hours or less. Within this unit patients are assessed, triaged to a medical specialty, referred to other hospital units, treated or discharged home depending on what is deemed most suitable for the individual patient. The unit is staffed by a number of different teams and professionals. The medical team is consultant led and is made up

of acute medicine specialists and junior doctors. Teams from other medical specialties also visit the unit if a patient has been triaged to their specialty. The nursing team based permanently on the unit is a large workforce of registered nurses and health care support workers. Each day the nursing team are co-ordinated by a senior staff nurse or sister who is responsible for the staffing across the unit as well as the movement of patients through the unit. There is also a Pharmacy team dedicated specifically to the AMU to facilitate the medication management for all patients on the unit. An intermediate care team which is funded by the local community NHS Trust is also present. This team is made up of community matrons. They assess and decide whether a patient is suitable to go home as well as make onward community referrals to ensure the patient is well supported after discharge. This team has a remit of admission avoidance. Working closely with this team is the Physiotherapy team (one senior and one junior physiotherapist) whose role is to assess any changes in mobility and help inform discharge suitability and onward referrals and planning. Between January 2013 and January 2014 this AMU saw 11,976 admissions of people over the age of 65.

5.6.3 Negotiating access

At the beginning of the studentship, a key contact was provided by the funders – the current AMU matron. In the development of the research protocol, the matron was consulted and she also advised consultation with one of the acute medical consultants who had an interest in research. Some key staff members were shadowed to ensure that the planned research would be feasible within this environment. This also ensured a familiarisation with the paperwork and systems in place on the unit. However, as is often the case in acute NHS hospitals, some changes had occurred in the window of time between this shadowing and the fieldwork beginning. The researcher's clinical role in the hospital was also crucial to field access as electronic identification and door access was pre-arranged and clinical experiences had allowed a familiarisation with hospital layout, organisational policies and expectations.

Following the receipt of ethical approval an email was sent to all members of the staff on the unit (Appendix B) accompanied by a copy of the research poster (Appendix C). The contact details of the recipients had been given to the researcher by the Matron and the Consultant. They had also advised the researcher to email the research poster to a member of the administration team for them to print out and display in staff work areas. Unfortunately, following receipt of this email the Clinical director of the AMU contacted the researcher informing her that no research should take place until they had had a meeting. This was naively unexpected, as the researcher had assumed that the matron and consultant had had the authority to provide permission for this research to take place. A meeting with the clinical director was then booked. Due to the clinical director's

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busy schedule the commencement of the data collection was delayed by two weeks. During this meeting the process to date, the aims of the study and who had been involved in providing access for the researcher was explained. The clinical director was then happy for the research to continue.

Accessing health professionals to arrange job shadowing and or invite them for interview in the second phase of data collection was difficult. The aforementioned gate keepers, matron and consultant, provided the key contacts that represented each professional group; nurses, pharmacists and the intermediate care team. The researcher liaised with all of these contacts via email and followed up with a telephone call. Gaining and maintaining contact with the Pharmacy team was problematic. Initially a positive response was gained from the team leader but this contact was not maintained. A second contact within Pharmacy was then pursued. This contact was also initially positive but was not fruitful in ensuring the engagement or participation of members of the Pharmacy team in the research.

The nursing and intermediate care teams agreed to participate. Due to staffing levels and the intermediate care team's busyness a total of five monthly meetings were cancelled. They had requested the researcher piggy-back these meetings for group interviews however on the fifth cancellation it was deemed that job shadowing would be a more feasible way to gather data from the intermediate care team's perspective. A group interview for the ward nursing team was arranged at a shift overlap time close to the unit.

To gain the engagement of consultants one of their monthly meetings was attended. In this, the research aims and processes were explained. All attendees appeared interested in taking part and appeared to appreciate the importance of the research. They suggested I contacted them via the medical secretary with a list of possible dates and they would get back to me. Unfortunately, despite emailing a short list of dates to all six consultants, no replies were received.

Negotiating access generally had been an unexpected challenge. It came as a shock to have to negotiate access to a place that if I'd had my clinical uniform on I could have strolled onto without anyone noticing or worrying. However, it was naïve to have not foreseen the need to gain consent or at least meet informally with the clinical director. Anticipating this may have made access easier, would have saved time and prevented delay in data collection. It was a very anxious time whilst awaiting a meeting with her and was not ideal in preparing for the new role of fieldworker nor the new experience of fieldwork. I was enthused by the interest and positivity of all those approached to be involved in the study from all professional groups. However the lengths that needed to be reached to book in any scheduled time for research activity largely failed and were extensive. However experiencing this difficulty led to further understanding of the psyche of those

working on the AMU and how quickly activities not deemed necessary to day to day clinical achievements can be routinely and consistently deprioritised.

5.6.4 Two research phases

The first phase of data collection was driven by recruiting patient participants. Participants required 24 hours in which to deliberate their consent which limited the window of observation and data collection. Therefore apart from general environmental observations, the majority of the data from this phase was garnered from interviews with patients in their homes.

It was therefore necessary for a second phase of data collection to take place. During this phase a change of focus towards the health professionals was needed as it was felt saturation had been achieved with regard to patient experiences as the experiences raised had become repetitious. This made the fieldwork process easier as not as much time was required to facilitate informed consent processes as patients were not required to be active research participants. The research phases are pictured below in Figure 7.



Figure 7 Research phases

5.6.5 Patient focussed research phase

During the patient focussed research phase the AMU was visited approximately 4 days a week over a six week period (between the end of November 2014 and the beginning of February 2015). The two weeks over the Christmas and New Year period were not used for data collection as it was understood these would be abnormal weeks with abnormal service provision due to national bank holidays. During this period in the field older people and their relatives were recruited for observation and interview. During the shadowing conducted prior to research protocol development it was clear that discharge planning and decision making occurred mostly in the mornings and then throughout the day. Therefore, visits to the unit fell within the hours of 7am to 7pm. For the majority of the time visits were on weekdays with the exception of one Saturday.

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Seventeen morning nursing handovers were observed as it was expected that these meetings would be an optimal time for discharge plans to be discussed. Six nursing handovers occurred concurrently each day - one for each individual bay. The nursing handover observed therefore alternated each day to ensure the same bay was not observed consecutively. On average, approximately two hours of observation per patient recruited was achieved. Field notes were kept throughout these observations as events unfolded and a reflection was also completed daily. Some field notes of observations when health professionals discussed discharge with patients consisted of a predetermined observation framework (Appendix D). The majority of field notes however were unstructured, guided more by the intrinsic interest of the study (Simons 2009).

Throughout the patient focussed phase of the field work I was conscious of where to stand and how to be in the field. Each day I walked around the unit so that I was able to observe the environment from many different locations rather than remaining static in one place. On reflection this was a response to the following;

- *the discomfort I felt in being still and “in the way”*
- *the pace of the unit making me feel that I should be constantly on the move*
- *the sprawled out layout of the AMU and the want to experience the sights, sounds, smells from all different angles.*

When I wanted to focus my attention on recruited participants I alternated between sitting at the desk and sitting at the patient’s bedsides. I found the desk location to be the most helpful as I would often catch the inter-professional discussions that would occur out of earshot (but not sight) of patients. Sitting by the bedside was not always comfortable for patients and therefore did not happen for very long at any one time.

5.6.5.1 Identifying and recruiting participants

The observed nursing handovers were the primary way of identifying potential participants. In these nursing handovers medical plans were discussed, but the extent to which discharge plans were discussed was limited. Therefore, a level of clinical reasoning was required as to the likelihood of each patient going home from the AMU. If any information was unclear the researcher would ask the nurse in charge for more information once handover had been completed. Potential patient participants were also identified during the researcher’s walk rounds of the unit. During this time the researcher would visit all of the bays and ask the nurse in charge whether there was anyone who was over 65 and likely to be going home from the AMU.

Inclusion and exclusion criteria (Table 4 and Table 5) were identified before the fieldwork commenced to ensure that the participants would truly represent the phenomenon at the focus

of this research. These included ensuring that patients were aged over 65, able to speak English, have capacity to consent to taking part in the study and have undertaken the expected pathway of being admitted to AMU via the Emergency Department or their GP. Exclusion criteria included those patients whose permanent address was a residential home or care home, whose condition was deteriorating and those who had recently (within the last 4 weeks) been admitted to the AMU already.

Table 4 Inclusion criteria patient participants

Inclusion Criteria	Rationale
Participants must be 65 years or over.	World Health Organisation (WHO) (2013) report that most western countries accept an older person to be someone who is 65 years or older.
Participants must be able to speak English	To ensure richness and depth of data collection. Although this may not allow findings to reflect the potential multi-cultural environment of the unit nor capture discharge decision-making when communication is a big obstacle. It was deemed unfeasible to arrange an interpreter within the time and resource constraint of this study.
Have capacity to make the decision to take part in the study	This is to ensure that patients are protected. This will be established by health professionals to ensure that informed consent can be gathered in accordance with the Mental Capacity Act (2005). Due to rapid turnover of patients, there is not time to feasibly consult a consultee.
Participants must have come straight from the Emergency Department, Observation Unit or other short stay department of the hospital or direct to the AMU from home.	To ensure the experiences of those for whom the unit was commissioned to provide care for are captured. In the unlikely event that a patient who should be treated elsewhere is an outlier on the AMU they will not be included in the study as they are unlikely to be discharged from the unit.

Table 5 Exclusion criteria for patient participants

Exclusion Criteria	Rationale
Participants must not have been admitted to AMU more than once in the last 4 weeks.	A readmission is accepted to be an admission within 30 days of discharge. Often, a readmission is considered an extension of the original care episode and will therefore have a different experience to those who have not been recently readmitted. Those who have recently been readmitted may find it difficult to separate their experience from their current stay in hospital to previous experience and therefore their experiences may not correlate to other findings.
Patients who have permanent addresses that are nursing homes or residential homes	The needs of patients who return to nursing home or residential home are different to those returning to independent living. These discharges involve a different type of planning, communication and transfer. It is likely that the discharge decision-making for these patients would require separate investigation.
Patients who have palliative needs, unstable conditions or people whose medical status is deteriorating.	For these patients, discharge discussions may not be appropriate at current stage in their care trajectory. Participation in the study at the end of life may add undue strain to a hospital and discharge experience and adds further complexity to follow up.

If patients appeared to meet these criteria the researcher approached them with an information pack. The pack included a research poster (to ensure that the researcher could be recognised) (Appendix C), a summary information sheet (Appendix E) and a supplementary information sheet (Appendix F). The supplementary information sheet used the format recommended by the NHS Research ethics guidance. To maximise recruitment and in alignment with the recommendations of the patient and public involvement group, the summary information sheet was designed to have larger print and fit on one size of A4. This sheet signposted potential participants to the supplementary information sheet should they require more information. This sheet was read out

to all potential participants unless they did not feel it necessary. The recruitment of older people in inpatient settings, particularly within the first few days of their admission, can be difficult so strategies such as taking time to explain, ensuring surrounding hospital staff were aware of the research, making clear the benefits and providing tailored information and communication were implemented (McMurdo et al. 2011).

The teach-back technique was employed to assess the participants' understanding of the research and therefore their ability to provide informed consent (Kripalani et al. 2008). This involved asking the participants to report back in their own words the study information and therefore allowed the researcher to ascertain their ability to understand, weigh-up and make a decision to be involved in the research as per the principles of the mental capacity act (Department of Health 2005). If they were unable to provide informed consent they were excluded from the study. Patients who had been assessed by the nursing or medical team to not have capacity to make decisions about their discharge were also not recruited as it was deemed unlikely that they would have capacity to make research participation decisions.

If they did have capacity to decide to take part in the research they were revisited at least 24 hours later and asked to complete a written consent form (Appendix G). This form was filled out either in the patient's own home or in their bed space if they were still on the AMU after 24 hours. During initial discussions the researcher explained that if patients were to leave the AMU for another ward or clinical area, the researcher would not be in touch.

Each day the receptionist on the unit was able to indicate which potential participants had been discharged, moved or remained on the AMU. If they had gone home, the researcher rang them on a number they provided to arrange an interview. If they had been moved to another unit they would not be involved any further in the research. If they remained on the AMU, patient focussed observation would take place.

Patient's relatives were recruited to the study via the patient participants. During initial recruitment conversations patients were asked if they had a relative who may also be interested in taking part. Sometimes the relatives were present with the patients at the time that the research was being explained. If the patient consented, they either provided their relatives' contact number or requested the researcher leave a relative information pack with them. This pack contained similar information to the patient information except tailored for relatives; a research poster (Appendix C), summary information sheet (Appendix H), supplementary information sheet (Appendix I) and consent form (Appendix J). For all of the relatives, consent forms were completed in the patients' home before the interview commenced. Inclusion and exclusion criteria were also set for relatives (Table 6) to ensure that they were able to provide

understanding and comment on the phenomenon of discharge decision-making in the AMU.

Relative participants were automatically excluded if patient participants did not consent to them taking part. Relatives needed to have taken an active role in the patient's care, have capacity to make the decision to take part and be able to speak English.

Table 6 Inclusion and exclusion criteria for relative participants

Inclusion Criteria	Rationale
Participant should have an active involvement in the life of the patient as a relative or carer as identified by the patient.	This ensures that relatives/carers are more likely to have a real understanding of patient's day-to-day needs as well as their discharge needs.
Participants have capacity to make decisions to take part in the study	Should the researcher have any concerns about the capacity of the relative/carers, they should not be included in the study in compliance with Mental Capacity Act (2005). Or if the patient has alluded to issues with capacity.
Participant can speak English	To ensure richness and depth of data collection. As time and resources will be limited, arranging an interpreter for those patients who may not be able to speak English will not be feasible in this study
Exclusion Criteria	Rationale
The patient participant has not consented to contacting relative or carer	As documented on the consent form, if consent has not been given for the researcher to contact a relative, regardless of the reasons behind it, the researcher will adhere to this to ensure that the patient participant is protected ethically.

5.6.5.2 Interviews with patients and relatives

Interviews with patients and their relatives were conducted in order to illuminate the experiences and perceptions of these key stakeholders in the process of discharge decision-making. Interviews took place at the homes of all patient participants and lasted between one to two hours. All relative participants were interviewed alongside the patient participants except in one circumstance. The interviews loosely followed the interview schedules (Appendix K for patients and Appendix L for relatives) but remained conversational and allowed for personal stories to be developed.

Each interview was recorded using a Dictaphone and transcribed verbatim. Audio recording provided an accurate report of the conversation and meant that the researcher could fully engage with the participant without the distraction of note-taking (Simons 2009). A downside to this was a lack of reliability of the equipment; in one instance data was lost due to a corrupt audio file. As field notes were recorded after each interview, the key messages and experiences from this interview were not lost. Interviews were all arranged at the patient's home as this was deemed a social environment where the participants had most control (Rubin & Rubin 2012).

In instances where relatives and older people were interviewed together the schedules were used flexibly to ensure all topics were covered from each participant's perspectives. This flexible and conversational approach aligned to Rubin and Rubin's (2012) interpretation of research interviews being '*Conversational Partnerships*'. Acknowledging that interviews are social events and therefore both interviewer and interviewee are participants, I recorded observations and reflections after each interview (Hammersley & Atkinson 2007). Transcripts were shown to the supervisory team who offered feedback on the interview technique. In this instance, a conversational style of interview worked well in developing rapport and enabling empathy (Rubin & Rubin 2012).

As well as formal semi-structured interviews, less formal and naturally occurring in situ oral accounts were also documented as field notes to further the thick description (Hammersley & Atkinson 2007). Sometimes these occurred without prompting during a social interaction (i.e. between hospital staff or relative to patient conversations). Questions were open, generic, appropriate to the situation and not invasive. Patients were only asked these questions if they had already provided informed consent. Patients observed as part of the practice focussed research phase were not asked any probing questions.

5.6.6 Practice focussed research phase

In the second phase of data collection a focus on clinical practice and the health professional perspective was required. During the first phase of data collection, observations had been limited by recruitment and consent processes and thus naturalistic data and data regarding the individual experiences of health professionals lacked depth of exploration. After some initial obstacles with recruiting health professional groups (as referred to in section 5.6.3 -Negotiating access) it was decided that the researcher would adopt a flexible approach to fieldwork and work with the health professional groups to determine the most appropriate method of data collection for them.

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Originally it had been decided that professional specific group interviews would have been an ideal method for this phase of data collection. Group interviews are useful in allowing comparison between different groups of people, which was viewed as particularly beneficial for this project (Flick 2007). One risk factor in developing the protocol and planning for these interviews however was ensuring the group dynamic was appropriate and that there was not an imbalance of power within the group (Freeman 2006). With this in mind, and agreed upon during meetings with health professionals on the unit, focus groups were planned to be profession or team specific rather than multidisciplinary. The relationship between different health professional groups is complex and issues of hierarchy and seniority are relevant. Additionally, focus groups allow for an identification of group norms and socio-cultural behaviours which will inevitably differ between professional groups (Hennink et al. 2011). As a result all arrangements for further data collection in this phase of fieldwork were specific to each professional group.

From summer 2015, concerted efforts began to try to book in fieldwork activities with each professional group. Both nurses and junior doctor staff groups gave their preference for group interviews. The intermediate care team and consultants both identified that job shadowing/observation would be the most suitable way to data collect for them.

5.6.6.1 Fieldwork, field notes, observation and job shadowing

In total approximately 30 hours of fieldwork was completed centred solely on the clinical practice of discharge decision-making. The times spent on the AMU completing group interviews, attending meetings and recruiting also provided opportunities for fieldwork and field note writing.

The majority of observation took the form of job shadowing. In this, the researcher followed the professional around as they completed their tasks that day. All those observed took responsibility for asking the patient's permission when interactions with patients were observed. No patients objected to observations in this manner. During this time the researcher asked clarifying questions of the professionals but usually once they had finished with their clinical assessment or discussion to ensure the naturalism of the interaction was observed, as well as to minimise the researcher's impact on the patients involved. Field notes were recorded throughout in a mostly ad hoc personal short hand. These were then expanded upon into more long form passages while the professionals were documenting their clinical interactions. Field note writing was fairly overt, which assisted in the building of trust with health professional participants as the intentions of the research were clear. At the end of each period of job shadowing time was taken to write down some remaining reflections and make sense of any jottings or notes from the day. The following

day the entirety of these notes were written up in a more cohesive way. Sometimes the field notes were added to at this stage with a further level of reflection.

Whilst job-shadowing health professionals I often became a sounding board where they would vent their frustrations, clinical reasoning and current thinking regarding the patient they had just assessed, the person they'd just spoken to or their role or situation as a whole. In addition to this increased level of insight, in the second phase of fieldwork I had access to new areas like offices and lunch rooms as well as the clinical areas I had grown accustomed to. Although I didn't write notes during lunches for example, this increased level of access added depth to my understanding of the cultural norms and organisational practices. Sometimes those I was shadowing would have to attend to another pressing matter (phone call, photocopier etc.) and leave me. I dealt with these instances in a similar way to my approach in the first phase of fieldwork. I'd position myself at a nursing station, introduce myself to the nurses, check it was OK to take up a space and make notes about what was going on around me.

5.6.6.2 Group interviews

Group interviews were carried out with the nursing team and the junior doctor team. Key gatekeepers for both groups decided that given their complex work patterns and intense workload, group interviews would be preferable to being observed or job shadowed.

Junior doctors had regular scheduled teaching sessions held over lunch times. One of these sessions was used to facilitate the group interview. The consultant who ran the session requested that the researcher provide an element of education in addition to the group interview to justify the use of educational time. The consultant asked the permission of the junior doctors who were on the rota that day to ensure they were happy with this plan. In this email the consultant included the information sheet (Appendix M), consent form (Appendix N) and demographic details form (Appendix O) as provided by the researcher. No one raised any concerns about the group interview happening in place of the normal education schedule.

The group interview took place in the AMU seminar room (the location for both the nursing morning meetings and the medical handovers – see map Appendix U). The consultant remained in the room throughout. This could have brought with it a level of observer bias in the responses provided by the junior doctors as he is their senior colleague and may be involved in the tracking of their development as doctors. However, as he was a key gatekeeper for the research and responsible for the running of this session it was not deemed appropriate to ask him to leave. Additionally, during the session, he helped to gain the consent of those who arrived late once the session had commenced. The structure of the session was as follows;

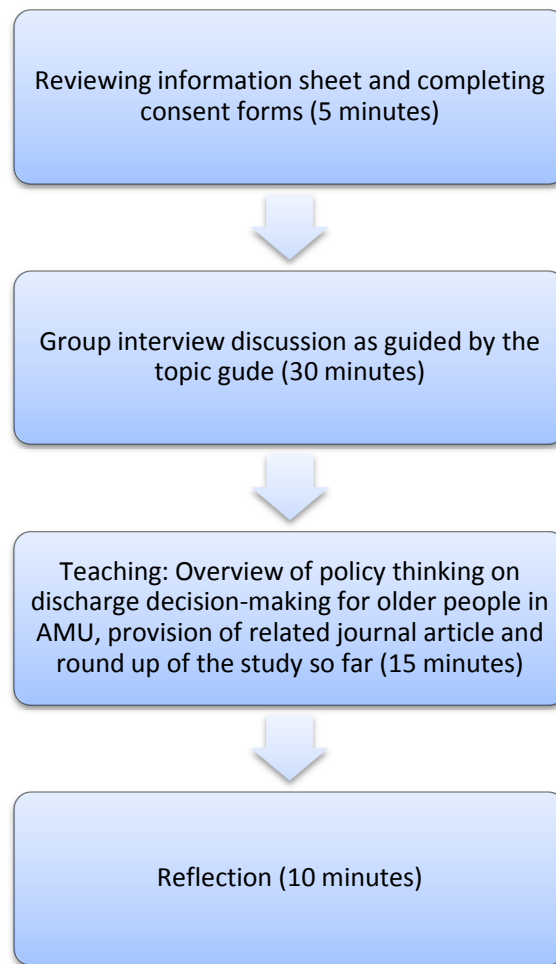


Figure 8 Junior doctors interview structure

The topic guide used can be found in Appendix P.

To arrange a group interview with the nursing team, the matron advised I liaised with a senior sister. The senior sister provided ten email addresses of nurses who had expressed an interest in attending the group interview. The researcher booked a room and chose a date and a time at which two shifts would overlap to encourage optimal participation. An email was sent to these ten potential participants with the information sheet (Appendix M), consent form (Appendix N) and demographic details form (Appendix O). An electronic diary invitation for the session was also sent. None of the ten nurses responded to either of these invites. A week before the session the same email was re-sent. The day before the session was due to take place I liaised with the senior sister to ensure everything was going ahead. She raised some concern regarding the lack of replies from the nursing team and advised that the charge nurse be contacted on the morning of the session so that she could ensure the nursing team were aware of the interview in their morning meeting. The charge nurse also phoned each AMU bay an hour before the session for a further reminder. This session lasted one hour and took place on the hospital site in the education centre, a separate building about a ten minute walk from the AMU. As the session was

independent of any existing meetings or education session, the full hour was taken for guided discussion. The topic guide can be found in Appendix Q.

In both group interviews, light refreshments were provided including cold drinks, cakes, biscuits, crisps and fruit. In each session participants were sat in a circle with the researcher as part of the circle. The junior doctors sat round a table and the nurses sat on sofas around a coffee table. In the junior doctors session the consultant sat in the corner away from table. The entirety of the interviews were audio recorded. Once the focus groups were completed the researcher immediately wrote a field note including any surprises, initial ideas about findings and reflection on methods and facilitation. The audio recordings were then transcribed verbatim by the researcher.

5.6.7 Documentary evidence

Documentary evidence was collected across both field work phases. The analysis of documents is crucial in ethnographic and case study research approaches as it provides information from a perspective that may not be captured through other methods; this information can be used to corroborate or contrast other data sources (Hammersley & Atkinson 2007).

In the patient focussed phase, excerpts of consented patients' notes were transcribed as documentary evidence. In total fourteen excerpts were transcribed anonymously from three participants' medical records. A framework for transcribing the excerpts was used (Appendix R). Only excerpts pertaining to discharge planning or going home were transcribed. In both phases, standard paperwork such as leaflets and blank assessment forms were collected if they were relevant to discharge planning and the norms of the AMU. Leaflets used to communicate with patients and relatives and assessment forms and patient notes used to document clinical reasoning and communicate between professionals provide insights into the priorities and messages of the organisation. Patient records also provide a timeline of events in hospital.

On the AMU patient records are paper ward-based records with a mix of standardised and non-standardised paperwork. They were organised according to the patient's bed number in a ring binder. The researcher had familiarity with this format as it is used elsewhere in the hospital. These extracts were transcribed into the pro-forma (Appendix R) at the nurses' station and records were not removed from this area. These were then uploaded to NVivo. For all other documentary evidence (assessment forms, leaflets etc.) a blank copy was located, photocopied and uploaded to NVivo with all other data.

5.7 Data analysis

This section provides a justification for the choice of the constant comparative method and a description of the processes of data analysis undertaken. The explicit account of data analysis activities provided here ensures that procedures and thinking are absolutely clear. This follows the advice of Ellingson (2013) who advocates detailed accounts of analysis methods to prove that the depth of analysis was sufficient and to provide clarity as terminology as approaches across qualitative research can vary widely.

5.7.1 Justification for using the constant comparative method of data analysis

In ethnography a prescriptive recipe for data analysis is deemed inappropriate for an in-depth analysis to be achieved (Hammersley & Atkinson 2007). However, an iterative approach of making sense of data is recommended, where ideas about the findings are used to understand the data and the data is used to further develop the ideas (Hammersley & Atkinson 2007; Murchison 2009). This interplay between data and ideas allows the concepts to emerge and is akin to a grounded theory approach (Hammersley & Atkinson 2007).

The original development of the constant comparative method of data collection related to a perceived gap between approaches to data analysis in grounded theory. One approach was deemed to crudely quantify qualitative findings and another that was deemed to use data to develop theory without coding or any systematic process (Glaser & Strauss 1965). Constant comparative method aims to facilitate analysis but is not a replacement for the iterative process of interpretation and thinking involved in any qualitative data analysis (Glaser & Strauss 1965). It also enables the analysis of a number of different data sources making it an appropriate choice in interpreting the findings of this ethnographic study (Glaser & Strauss 1965).

Hammersley and Atkinson (2007) write that systematically sifting through data and comparing concepts enables the identification of relationships, ideas and features that may transcend the individual contexts of data sources. Using the constant comparative method of data analysis and Glaser and Strauss (1965)'s stages for guidance assists in the identification of contradictions and inconsistencies that enrich the level of understanding (Hammersley & Atkinson 2007).

5.7.2 Data analysis processes

In-keeping with the ethnographic approach, the analytical process began during the formulation of research questions, foreshadowed problems and research design (Hammersley & Atkinson 2007).

Glaser and Strauss (1965) separated the constant comparative method into stages but were explicit about the fact that it is not a linear method where one stage finishes and another begins, rather, stages may be continuous until the analysis ends. These stages of data analysis are as follows;

1. Comparing incidents applicable to each category
2. Integrating categories and their priorities
3. Delimiting the theory
4. Writing the theory

(Glaser & Strauss 1965 p.439)

In this study the data analysis process was aided by the use of NVIVO software to manage the data and codes. Although acknowledging that the use of data analysis software can be misused to oversimplify analysis, it is condoned in instances where data has a number of sources and is typed or transcribed verbatim, providing that it is not used in lieu of analytical thought and interpretation (Murchison 2009).

An in-depth knowledge of the data is first required before any formal steps towards analysis are taken. Familiarity with the data was achieved by the researcher undertaking all fieldwork, transcription and transcription checking tasks. Then, the initial coding of categories was initiated. Each data source was individually coded. Codes used during this first cycle could be described as 'descriptive coding' and 'in vivo coding' (Miles et al. 2013). Where possible 'in vivo' codes were used where the code reflected the original words of the participants (Stanley 2006). In order to manage the breadth of these codes a coding diary or log was kept and updated regularly. This process allowed for comparison of the data coded as well as the identification of duplicates (Glaser & Strauss 1965). It also facilitated the reworking and redefining of initial codes as needed. A coding log was kept providing a description of each initial codes. During the process of coding, over-arching categories or themes were becoming evident. These were grouped together under 'parent-nodes' using the NVIVO software. Similarly, the 'relationships' function of NVIVO to facilitate 'causation coding' to indicate where codes may contradict each other, be associated with one another or where one code could be seen as enabling or inhibiting another code (Miles et al. 2013).

Once all the data from the first phase had been coded further development was required to substantiate the emerging categories or themes. An exercise that facilitated this process was mapping on paper. Using a large sheet of paper each code was written out, creating links in order

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to inform category and relationship development. Every code was included even where experiences, observations or reports were contradictory. This process was similar to the generation of 'Positional maps' which seek to represent the full range of findings allowing different positions and issues to arise (Clarke 2003). Clarke (2003) developed the use of mapping in situational analysis to support grounded theory methods of data analysis. She proposed the use of positional maps, situational maps and social-worlds maps as ways of exploring complexities in data. In this instance the mapping exercise led to the adjustment of categories and further development of relationships between codes (Glaser and Strauss' (1965) stages 1 and 2).

A second mapping exercise with a different aim followed this. This time whole categories were mapped to the objectives of the research. This process intended to work out the extent to which the objectives had been met from the existing data (Hewitt-Taylor 2001). This process also helped to delimit the evolving theories as many codes and categories were broadened, separated, redefined or further focussed. These initial findings were then brought together and written up to inform phase 2 of the research. Parallel analysis alongside data collection is often completed when using the constant comparative method to inform focus in later phases of the fieldwork (Featherstone et al. 2015). Throughout this process further concentration and comparison of categories and codes continued.

Following the second research phase initial coding took place again. This time an analysis memo log was kept as in this phase decisions on importance and relevance were required in order to begin to find the focus of the findings. Keeping this log was prioritised so that ideas were written down immediately and the researcher was cautious not to standardise the memos or self-censor in what she was writing (Miles et al. 2013). Codes were deleted if they had a singular reference within them, or if they were tenuous in content, not deemed to have importance or were referencing an aspect of care that did not become important as the data developed. Using all of the data across both research phases, codes were continually redefined, condensed and sometimes expanded. During the first phase of data collection, all codes were kept in case they should develop to become significant, but the second phase of data collection allowed for focus to develop. A 'spare nodes' folder was kept for codes and categories that were deemed less important to ensure they were not lost should they require retrieval as the analysis continued. As with the initial data analysis processes in the first phase, a coding log was used to describe the codes and reflect on their importance in the findings. This was used to explore how each category related to one another. A copy of this log can be found in Appendix S. Five hundred and seventeen initial codes were gradually condensed to 33 parent nodes or categories. Other tools used for making sense of different aspects of the data were descriptive vignettes, matrices and flow charts— some of which were then used in the presentation of findings (Miles et al. 2013).

In the above I have tried to tease out exactly the steps that were undertaken in trying to make sense of the data (in the interests of explicit methods and trustworthiness). The above represents what was done in the data analysis process but may not necessarily capture all that the practice of data analysis included.

The data analysis process was less clear-cut. It felt messy and it looked messy in whichever form it took. It was overwhelming both due to the volume of data but also the emotional and personal attachments and experiences that were interwoven in the data too. It was time consuming and I often had to take breaks from it and return to it with fresh eyes.

After some time of sifting through and re-jigging using NVIVO functions, mapping was particularly useful to me in piecing things together and being able to see the data 'laid out' in front of me. These maps were often large and unwieldy and were continually drawn and re-drawn and revisited at different time points. I found that documenting and moving my data around in different formats helped (NVIVO, coding logs, different maps, vignette, models, flow charts). One of the largest challenges was uncoupling myself from my data and making judgements on importance. It was almost as though I felt a duty to the data to not exclude anything, particularly when I was able to recall the context of the data (a quote or a specific moment in time) and particularly if it was clear that the participant who provided that quote or that moment felt it was of great importance to them. I had to be conscious to move between 'focussing in' and 'helicoptering out again' to ensure my findings were representative of the data as a whole as well as individual experiences and observations.

My approach to working out what was of most significance, was to write up the findings as though I was reporting on everything. Although time consuming and likely indicative of my own indecision, this was a helpful exercise as once everything was reported it did become clearer which findings were the strongest, well-grounded findings as well as the most important ones.

There was also additional pressure, bred from the nature of qualitative data analysis of a constant concern for doing it "right" and doing the data justice. Supervisory meetings were of great use in dealing with this pressure – particularly as they were less entrenched in the "details" of the data and were able to offer a different perspective.

A final challenge related to being a health professional and having tacit knowledge of the field (or at least familiarity) was being conscious of and aware of the differences between data and my personal experience or interpretation of the phenomenon within my tacit knowledge. I paid attention to this at great lengths during field work, in particular my situational identities (of Occupational Therapist, student and ethnographer) and their impact on the practice of field work

and of field relations (Rule 2018). However, I had not acknowledged fully how much my tacit knowledge and previous experiences may infiltrate or interweave within the data. This is likely a challenge that will be faced by any researcher new to ethnography or qualitative research in general and anyone with familiarity to any extent in a certain field. Aside from being conscious of it, and re-reading and re-checking interpretations to specifically check for it – the use of an external, separate person (in this case the supervisory team) also assisted in detecting this. This does not mean to say that my personal experiences was completely removed from the analysis process (I do not deem this to be possible or feasible given the social nature of ethnography – see positionality statement in section 5.5.1) but rather identification of this as a potential risk allowed for an extra level of checking to see if the interpretation stood from a different view point. My use of multiple sources also provided reassurance on this. Lots of articles debate the “costs and benefits” of “insider-outsider” ethnographies and data analysis is a specific focus (Dwyer & Buckle 2009). The debate on this is not easily resolved, but Dwyer and Buckle (2009) advocate for an approach to analysis that is open, honest and committed to the experiences of those in the field.

A number of steps were then taken to ensure confirmability of the interpretations in data analysis; checking for representativeness, checking for researcher effects (reflexivity), triangulating data interpretation and coding with doctoral supervisors, checking the meaning of cases that appeared to differ, following up surprise findings (from phase 1 to phase 2), looking for negative evidence, checking for rival interpretations and seeking feedback from participants (Miles et al. 2013). A letter was sent to all participants with a brief description of the findings following the analysis of both phases of data collection. This letter provided contact details should they have any feedback or comment. No responses were received.

In using a constant comparative method to underpin this analysis, a technique from the grounded theory approach, the stages were used as guidance and not prescriptions to preserve the subtle realism of the study and prevent any tendency towards positivism that may not be true to the paradigm (Charmaz 2014). Additionally, the naturalistic nature of ethnographic research meant that a desire to describe things exactly as they occurred can overshadow an in-depth exploration of findings (Hammersley & Atkinson 2007). Other issues that the researcher was aware of throughout the data analysis was holistic fallacy, where events are interpreted as more congruent and clear than they really are, elite bias where data from the articulate receives more focus than data from others and personal bias where data is interpreted according to the researcher’s own positionality and agenda (Miles et al. 2013). To manage these potential biases, reflexivity was maintained throughout.

5.8 Ethical considerations in ethnography

Social and health research requires the consideration of ethics to ensure no harm is caused to those involved. Ethnography which involves the practice of fieldwork is inherently relational and therefore requires more specific reflection on the ethical quandaries that may come with these field relations. Throughout, the researcher operated within her professional code of ethics as per the Royal College of Occupational Therapists and the Health and Care Professions Council. These ethical considerations were all actively reflected upon in the planning stages, fieldwork stages, analysis stage and continue to be considered in the reporting and dissemination stages of the project. These ethical issues will now be discussed further. The ethical dilemmas associated with being a clinician were discussed in section 5.5.3.

Ethical approval for this study (REC number: 14/YH/1102) was granted by the Yorkshire & Humber NRES committee in July 2014 via the proportionate review service available for NHS ethics. Local research and development approval was achieved in November 2014.

5.8.1 Field relationships

Fieldworkers aim to understand and analyse a 'peopled field' in order to generate ethnographic understanding (Coffey 1999). Therefore this understanding is dependent upon the field relationships, social interactions and shared experiences between researcher and participants (Coffey 1999). Participating in ethnographic research should not result in harm, but at the very least, there is the possibility that being observed may induce a sense of anxiety, especially when participants are in stressful and worrying situations (Hammersley & Atkinson 2007). Life in the AMU can be stressful, worrying and anxiety provoking for all those present; patients, relatives and health professionals.

For health professionals, being observed can result in a sense of one's work or self being evaluated (Hammersley & Atkinson 2007). In an attempt to prevent this, the observation was framed in terms of job shadowing with the aim to understand what it is like to be the observed professional and what each of their jobs entails. For health professionals, job shadowing is an accepted way of learning and many health professionals will have had experience of being job shadowed by students, inspectors and other health professionals as they seek to understand their role and how it fits within the AMU. Framing the observation in this way ensured that it was not abnormal practice and rather something the participants would be used to.

Using the relational nature of field work, a level of trust was built between health professionals and the fieldworker. Factors that appeared to help build towards this trust was that the

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fieldworker was young, described herself as a 'PhD student' (i.e. not in a position of influence over the health professionals' practice and jobs), was previously unknown to most participants and aimed to explain the research in an open and non-judgemental way. The researcher was not a part of the hierarchy that is a commonplace aspect of hospital organisation and this helped with access to most professional groups.

Despite occasional probing, the researcher aimed to be inoffensive in her questioning of practice during observation. This aimed to ensure that health professionals were protected from feeling examined and access and trust were maintained. This is what Anspach and Mizrachi (2006) term the 'dilemma of discretion' where researchers purposefully withdraw questions that may offend or risk the field relationships that they have made. The concern with this discretion is that data may not truly represent a phenomenon if these potentially offensive or pervasive questions are not asked and the sensitive issues then not understood (Anspach & Mizrachi 2006). However, in the frame of NHS ethics, not wishing to cause offense or personal harm is an adequate justification for this 'discretion' as it aims to protect research participants.

For this research the context of the group interview was deemed a more appropriate environment for probing and the more difficult conversations. Here, professionals may be asked questions for which their answers provide critique or discussion on difficult topics. This is more comfortable than probing in the field as the experiences come from the professionals themselves rather than in a reaction to them completing their work. Questions inviting critique or questioning practice are likely to feel like personal criticism when they are directed at one individual and occur having watched that individual work.

Throughout the fieldwork, clear interpersonal boundaries were maintained where the 'small talk' of day to day data collection did not transcend into more 'personal' areas of talk. The fieldworker did not ask or record any data that reflected who the professionals were outside of their work as this was not relevant to the aims of the research.

For patient participants, relationships were built with the aims of openness and clear boundaries. This involved using the same skills used during clinical practice to develop therapeutic relationships. Although beneficial to encourage openness and trust, these kinds of relationship have further implications for the interpretation and reporting of findings ethically to ensure that this trust is not abused. There is a delicate balance between presenting and analysing critically and being critical of the professional's practice or the way patients and relatives conduct themselves whilst in hospital.

I tried to maintain reflexivity as I wrote up the field notes. I didn't want my relationships with people to interfere with the way I presented and analysed the data. I paid attention to whether I had a negative or positive association with data I was writing or analysing and tried to unpick why this was. In doing this I hoped to eradicate any negativity of tone that was due to an individual or a weaker relationship, thus not privileging the experiences of those I got on with better over those that I did not. While analysing and writing up, the relationships I made with people in the field remained at the forefront of my consciousness (Anspach & Mizrachi 2006).

Field relationships are also at risk in decisions regarding revealing and concealing (Anspach & Mizrachi 2006). The issue of highlighting negative events or bad practice in the context of healthcare needs to be dealt with in a clear-cut approach. Had dangerous practice been observed, the researcher was bound to raise this to staff managers and higher if necessary, despite any potential harm it could cause to field relationships. This was made clear to staff members prior to the fieldwork commencing. Coffey (1999) argues that ethical issues regarding the dimensions of field relationships and the consequences of fieldwork, dissemination and publication should not serve as arguments against ethnographic research but instead bolsters the need for fieldworker's to ensure reflexivity. Thus, continual reflexivity was deemed necessary in this project.

5.8.2 Informed consent

In line with NHS ethics processes and expectations, informed consent is represented by information sheets and written consent forms. This informed consent process was adopted for recruiting patients and relatives. Health professionals involved in audio recorded conversations were also provided with information packs and gave written informed consent. However, no formal consent process was carried out for those health professionals in the field at the time of observations and job shadowing. This was largely due to the impracticality of completing this and the expected disruption it would cause to gain written consent for everyone on the unit at any one time. Instead consent was assumed. The research was publicised to all staff members before the fieldwork began and they were encouraged to contact the researcher if they had a concern or wanted to withdraw. In addition, verbal consent was gained when people were observed on an individual basis. The right to withdraw or say "no" at any time was made clear to all participants and health professionals did exercise this right on some occasions.

In the field, informed consent was more of a 'negotiated process' (Pope 2005). Pope (2005) reported how in her experience of doing ethnography in medical settings (in particular operating theatres), she often felt the need to reiterate the fact that research was occurring by openly and obviously writing notes as a way of reminding participants. It is common that when being

observed participants can forget the purpose of the researcher's presence especially when they come to know them (Hammersley & Atkinson 2007). In this research project, similar tactics were used in order to remain explicit about the fact that research was taking place. These included obvious note taking, frequent self-introductions as 'researcher' and the constant behaviour of ensuring that the researcher's name badge, with the title of researcher/student, was front-facing and visible. Although in the interests of ensuring informed consent, this behaviour is good, it can mean that fieldworkers are distracted from seeing and feeling in the field in favour of ensuring consent processes are followed (Emerson et al. 2011). In this project in the first phase of data collection focussed on the patient experience, the researcher did succumb to Emerson et al. (2011)'s concerns of distraction.

In order to gain NHS approval I had had to compromise my proposed processes around informed consent for patient participants. My original protocol requested that patient participants were given as long as they wanted to deliberate their consent to join the study. I then planned to revisit their consent twenty-four hours later to ensure their answer remained the same but would begin data collecting as soon as they had provided their consent (be it after ten minutes, an hour, three hours or a day of deliberation). However the ethical committee felt that this was not essential to the research as it was not "emergency research" and instead recommended that the normal process of postponing data collecting until the patient is given 24 hours to deliberate consent was undertaken. Once the fieldwork began it became clear that waiting 24 hours was quite restrictive. I became quite pre-occupied with ensuring I was recording the time I met patients so that I could go back exactly 24 hours later. Often, patients had already gone home in that window of time and although they could still consent and have an interview once home, I missed opportunities for naturalistic data collection. The pre-occupation of informed consent processes did distract from paying attention to the field more generally. However, this was rectified by conducting a second phase of research.

5.8.3 Confidentiality and anonymity

The ethical responsibility of researchers to ensure confidentiality and anonymity is entangled in the field relationships as mentioned previously. In this case the intention to maintain confidentiality and anonymity was made explicit in the participant information sheets and verbally reiterated throughout.

All patient participants were asked to choose a pseudonym by which their interview, document and observational data was recorded, transcribed and reported. The purpose of this pseudonym was made clear to the participants. An Excel spreadsheet that stored the participants' information

alongside their pseudonym was password encrypted and only accessible by the researcher. Consent forms were kept in a locked cabinet in a locked room and all other data collection documents were kept in a locked cabinet in a different locked room on the NHS site as per the University of Southampton data storage regulations.

For health professionals, it was made explicit that the researcher would refer to them in the write up of the findings in a way that would protect their anonymity. For groups like doctors and nurses where there were many on the AMU this was not a problem. But for professional groups where there were fewer, more collective terms were used. Still, and largely due to the personal nature of the ethnographic approach, confidentiality and anonymity cannot be absolutely guaranteed. Again, careful consideration and reflexivity was required in what is chosen to be reported, disseminated and published to ensure adequate depth of understanding that isn't to the detriment of participants' anonymity.

5.8.4 Managing being a clinician

All study information provided to participants detailed the fact that the researcher is an Occupational Therapist. In the field, the researcher's identity (Occupational Therapist, researcher and student) was situational and negotiated depending on the field relations.

5.8.5 Ethical considerations in summary

This research was ethically bound not only by research NHS ethical approval but also by the researcher's own ethical principles and professional codes of ethics and conduct. In the field, ethical issues such as managing field relationships, informed consent, confidentiality and managing the responsibility of being a health professional were all well considered and reflected upon. Ensuring and considering all of these aspects is an iterative practice that continues as the findings are reported (below) and disseminated.

5.9 Chapter Summary

In this chapter the methods and methodology of this research have been described and justified. Ethnography was selected as it allowed a focus on the social phenomena of discharge decision-making for older people within its naturalistic context. Reflexivity was maintained throughout the research and the researcher's positionality as a white, young, female, subtle realist occupational therapist was described. Then the two phases of the research were detailed including the methods used within both. The initial research phase was focussed on the experiences of older people and the majority of the data came from interviews in patient's homes after discharge. The

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second phase focussed on the practice of discharge decision-making with greater focus on observation through job shadowing as well as group interviews. The constant comparative method of data analysis was used to interpret the findings. The details of what this entailed in practice have been provided. This chapter has concluded with a discussion about the ethical considerations required in completing this research. The next two chapters provide a breakdown of the findings of this research framed around the research objectives.

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Chapter 6: The context, environment and culture of the Acute Medical Unit and the impact on patients, relatives and staff

6.1 Introduction

This chapter commences with a report of the recruitment for this ethnographic study. The findings are then described and explored. Findings related to the first and second objectives are presented first. These objectives focus on the context of the acute medical unit and the impact that the context of the unit has on all those at the centre of it (older people, relatives and patients). Figure 9 provides a summary of the main themes throughout the findings and how the findings to each objective are related. The findings specific to the process of discharge decision-making will be explored in the following chapter.

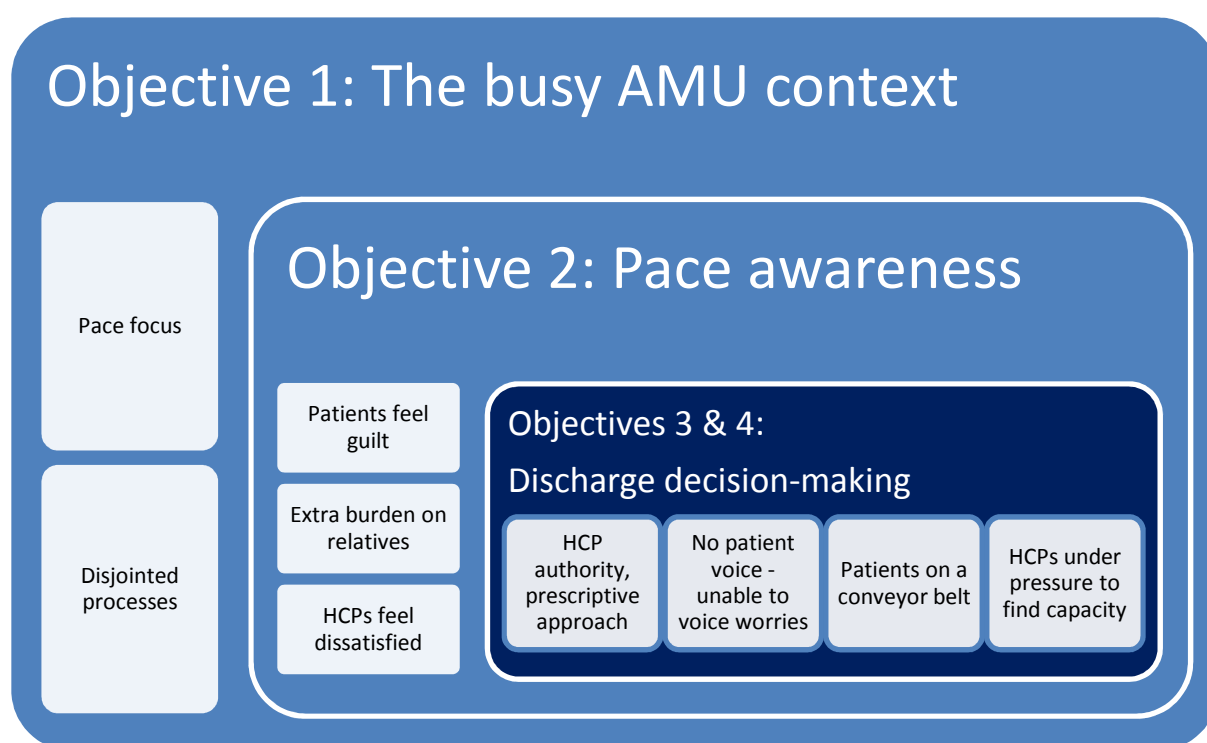


Figure 9 Model locating and relating findings and objectives

6.2 Recruitment

Twelve patient participants were recruited. Appendix T provides a patient recruitment flow chart. Three of the twelve participants provided informed consent whilst in hospital. Eight relatives were

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also recruited and interviewed with seven being interviewed at the same time as the patient. Four of the relatives were patients' spouses who lived with them and the remaining relatives were patients' offspring who did not live with them. Further information about the patient participants can be found in Table 7.

Table 7 Patient participants' information

Participant	Age	Admission route (via ambulance or GP)	Admission reason	Length of stay (nights)	Social situation	Relative interviewed	Number of days between discharge and interview
Mr Parrot	69	Ambulance	Shortness of breath	1	Lives with wife	Yes – wife	1
Mr Smith	77	Ambulance	Mismanagement of type one diabetes	1	Lives with wife	Yes – wife	6
Mrs Peach	81	Ambulance	Fall	1	Lives alone	No	1
Mr Orange	87	Ambulance	Fall	2	Lives alone	No	3
Mr Gilo	79	Ambulance	Fall	3	Lives with wife	Yes – wife	48
Mrs Andrews	91	Ambulance	Vomiting and confusion	4	Lives alone	Yes – daughter	33
Ms Jones	87	Ambulance	Exacerbation of angina	1	Lives alone	No	20
Mrs Norway	85	GP	Shortness of breath	2	Lives with husband	No	6
Mrs Adams	78	Ambulance	Exacerbation of angina	1	Lives alone	Yes – daughter	14
Mrs South	70	GP	Shortness of breath and low blood pressure	1	Lives with husband	No	15
Mrs Kelly	91	Ambulance	Transient ischaemic attack	2	Lives alone	Yes – son	23
Mrs Delahey	70	Ambulance	Fall	1	Lives with husband	Yes – husband	7
Averages	80.4			1.6			14.8
Standard Deviation	7.97			0.9			14.4

Participant information from the group interviews can be found in Table 8. Two very experienced nurses and five junior doctors with experience between six months and four years were recruited for group interview. Three intermediate care team nurses, one consultant geriatrician and two physiotherapists (N=6) were job shadowed. Various other health professionals were observed as actors within the field. The study was unsuccessful in recruiting pharmacists or acute medicine consultants for interview or job shadowing.

Table 8 Health professional participants' information

Focus Group number	Profession	Job title	Amount of time on AMU	Years worked since qualification	Highest qualification	Pseudonym
1	Nurse	Sister	17.5 years	24 years	BSc/DipHE	N2
1	Nurse	Staff nurse	18 months	31 years	Diploma	N1
2	Doctor	Foundation Year 2 doctor	2 months	1.5 years	MBBS, BSc Hons	D2
2	Doctor	Foundation Year 1 doctor	6 weeks	0.5 years	MBBS, BSc Hons	D4
2	Doctor	Senior House Officer	2 months	3 years	BM	D3
2	Doctor	Senior House Officer	4 months	4 years	MD	D1
2	Doctor	Senior House Officer	4 months	2.5 years	BM, BmedSci	D5

All patient participants chose their own pseudonyms. Relatives are referred to in the findings by their relation to the patient participants. Health professionals are referred to in the findings by their most anonymous description for example their profession or in instances where there was only one profession on the unit, the team they belonged to.

6.3 The pace focussed context of the Acute Medical Unit

The first objective of this study was to understand the context of the AMU within which the discharge decision-making process took place. In this section, the context, environment and culture is described.

The AMU is a 58 bedded unit that sits within a hospital under pressure and a pressurised NHS Trust. Routinely collected data of AMU admissions indicated that they received 11,976 admissions of older people (people aged over 65) from Jan 2013 – Jan 2014, an average of 34 older people being admitted each day. Most recently, the hospital has been publicly assessed as “Requires Improvement” by the Care Quality Commission (CQC)¹⁰. Specifically, the medicine speciality (including older people’s care and the AMU) were assessed as “inadequate”. In this context a ‘requires improvement’ rating is awarded when services are not performing how they should and the CQC have advised on how it can make improvements(Care Quality Commission 2017a). A rating of ‘inadequate’ is a step worse than ‘requires improvement’ and is the lowest rating that can be awarded. An ‘inadequate’ service is performing badly and the CQC have taken action against the organisation(Care Quality Commission 2017a). Potential actions that can be taken by the CQC include limiting what services can provide, placing a service under ‘special measures’ so that extra supervision is provided to the service and clear and time-limited goals for improvement are set or issue fines, warnings and in some cases prosecute those responsible where harm or danger of harm has been observed(Care Quality Commission 2017b). In the CQC’s final report for the Trust, this was written specifically regarding AMU.

AMU had bed occupancy significantly higher than the England average and escalation areas were consistently in use. Patients were moved both during the day and night for non-clinical reasons to aid bed availability. Patients did not have timely access to discharge from hospital.

Staff were frustrated and demoralised. Levels of staff sickness and staff turnover on AMU were above the England average and showing an upward trend. Staff did not feel listened to or connected to senior management. Allegations of bullying and harassment had been made directly to CQC and not all staff were aware of the process to raise concerns within the trust.

Quotation from the CQC report following their inspection in February and March 2015

Within this excerpt the lack of timely discharge access and the movement of beds to aid availability rather than for clinical reasons was observed. These observations were reflected in the data for this study. Further detail regarding the circumstances around the observations will be provided as the chapter progresses.

¹⁰ The Care Quality Commission (CQC) is the independent regulator for all health and social care services in England. It aims to ensure that services meet fundamental standards of quality and safety.

6.3.1 Setting the scene – introduction to the Acute Medical Unit

The AMU was an environment of constant flux. Below is a vignette, from field notes, that aptly describes the context of the AMU and what it is like to walk onto the unit at twenty past seven in the morning. It begins to describe how the unit changes at that time in the morning as the busyness sets in and then remains for the rest of the day. The vignette indicates the sprawled out nature of the layout of the unit with bays leading into bays, many corridors to get lost in and the lack of space. It shows how a symbol of the busyness - a flipchart indicating bed status is displayed for all to see at the entrance to the AMU. This sets all those on the unit's expectations for the day ahead and whether or not freeing up beds should be made a priority. This vignette begins to highlight the noisiness and activity that unfolds after 8am. A map of the unit can also be found in Appendix U.

On the right hand side, the receptionists prepare for the day ahead. A flipchart displaying the hospital bed status is on the top of their desk – it indicates red alert, limited beds available in the hospital.¹¹

On the left hand side is a waiting area with a TV screen and two vending machines. This is for people who come in for ambulatory care.

Beyond the entrance foyer is a short corridor with four clinic rooms that ends in a cross roads. Turning left would lead to Blue bay, ambulatory care, or Pink bay, now the discharge lounge. Turning right leads to the main bays of the AMU.

Red bay, with nine beds and two cubicle rooms sits opposite Yellow bay with eleven beds. At this time in the morning these bays are dark. The patients are still sleeping and the nurses are gathering the patients' notes and preparing for the morning handover. The normal hospital noises, beeps and machines, are present but they are softer sounding at this time.

Past Red and Yellow bays is a large meeting room where all of the meetings, teaching and trainings are held. Then Lilac bay sits at the end of the corridor with two cubicles and another nine beds. You have to walk through Lilac to get to Orange bay. Orange has 22 beds in total, but is really considered as two bays by the staff, 'Orange high numbers'

¹¹ The coloured alerts correspond to the NHS England (2016) Operational Pressures Escalation Levels (OPEL) Framework which are often referred to via a traffic light system were green (organisation is able to maintain patient flow and doesn't anticipate extra demand) is OPEL 1. This moves through amber and red with increasing needs for action and support until OPEL 4 (referred to throughout the findings, here, as Black Alert) where pressure in the system continues to escalate so that organisations are unable to deliver care. This requires decisive local action and if held at sustained level, national input.

and 'Orange low numbers'. Patients are allocated to the different bays according to their gender. During data collection orange has been for male patients and the other bays for female but the nurses tell me that this can change according to numbers – although it never did while I was there.

Yellow and Orange bays are spacious and large with every bed space having a view of the central nursing stations. Lilac and Red are small with a desk that only feels big enough for one computer and has more chairs than desk space.

At this time in the morning the lack of space isn't an issue, but once 8am hits things change. The lights are on; patients are awake, eating breakfast and telling the health care support workers what they would like for lunch. Call bell buzzers go off, buzzing every thirty seconds and the corresponding light above each bed flashes. The phones begin to ring continuously, one or two phones for every bay. The doctors come onto the ward and commence their ward rounds¹² in groups of two or three. The pharmacists set up shop in front of a computer. Health professionals' pagers go off every ten minutes. The health care support workers are getting the patients up, washed and dressed. Cardboard bowls of soapy water sit in front of the patients with false teeth, hearing aids and combs all lined out on their tables. The nurses wheel the medications trolley around to each patient, occasionally stopping to get some more information from another health professional and scribbling it down on scrap pieces of paper. Commodes, porters' chairs and beds containing people are wheeled in and out. Visitors arrive, curtains are drawn and undrawn. Now that 8am has passed, even spacious Yellow and Orange bays feel cramped, rushed and busy.

The excerpt above indicates the hive of activity that is the AMU during the day. Already pace is the palpable focus from the 'red alert' flip chart to the health care support workers already planning for lunch. It is not a relaxing place. The only constant throughout the day is the continuous movement.

For patients that arrive on the unit, in addition to the hive of activity as described above, there are other indicators that help to set their expectations that time is short on the AMU. In a 'Welcome to the AMU' leaflet that is left in waiting areas and theoretically distributed to patients and relatives as they arrive, these expectations are set (Figure 10). Within this, new arrivals to the unit are told that the unit is "always busy" and dealing with "acutely ill

¹² A 'Ward Round' refers to the medical team reviewing each of the patients under their care, one after the other. They move round the ward checking in on people and making assessments.

patients". It explains how the assessment process on the unit will be underway "within the first few hours". From the outset it is clear to those reading this leaflet that the unit has to be focussed on the quick throughput of patients.

Introduction

Welcome to the Acute Medicine Unit. This is where you will be assessed and your treatment started. The unit is always busy as acutely ill patients are admitted 24 hours a day, 7 days a week.

Within the first few hours you will be allocated to a team of doctors and nurses who will organise your care. The team will prioritise treatment according to the need of each individual patient. When a course of treatment has been planned for you we will then move you to another ward or discharge you home.

Figure 10 Welcome to the AMU leaflet

In addition the leaflet sets out that the medical team will prioritise the care of individuals on the unit according to their need. In other words, it is not "first come first served" and you will only be seen if you really need it. Already, the idea that some patients may be more legitimate or in need than others is introduced. Patient's self-perception of legitimacy will be discussed later in the chapter.

6.3.2 The pace priority in the Acute Medical Unit

The theme of pace as priority on the AMU transcended field notes, documentary evidence, interviews as well as staff and patient experiences. When asked about discharge planning processes in their group interview, the nursing staff reflected on the hospital and national policies for discharge that ensured that quick and efficient discharge planning was a priority.

N2: we plan from the moment of admission, that's when their discharge plans starts and the plan is we ... facilitate movement through the system back to their home,

N1: as quickly as possible

Nursing Group Interview

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The above quotation is particularly interesting because Nurse 1 felt the need to suffix Nurse 2's explanation with "as quickly as possible", as though the urgency was not evident enough from her description. She reaffirms that pace is the focus. "Movement through the system" is the priority and the default process.

For the intermediate care team, an awareness of the requirement for quick movement through the system was even more present as part of their day-to-day work. For every patient they completed standard forms that both served as initial assessment forms and data collection forms. These forms reflected the team's Key Performance Indicators (KPIs)¹³. As their remit was to support discharge and avoid admissions, the pace focus of their work began from picking up the referral. Figure 11 and Figure 12 give examples of the time specific KPIs that the community team were expected to meet. If they were unable to discharge someone within 48 hours, they were expected to justify why, particularly if that patient was "medically fit".

Seen within 60 minutes of referral/identification	Yes	<input type="text"/>	No	<input type="text"/>
Seen within 60 minutes of arrival:	Yes	<input type="text"/>	No	<input type="text"/>
Patient Gender	Male	<input type="text"/>	Female	<input type="text"/>

Figure 11 Key Performance indicator – patients being seen within 60 minutes

¹³ If the team do not meet their KPIs, there is a risk that commissioners may not pay for their service again or to the same level.

2) SUPPORTED DISCHARGE:

From: **Obs Ward** **AMU**

Time:

Within 24 hours

Within 48 hours

Within 72 hours

Over 72 hours

If over 48 hrs - please indicate whether pt was medically fit:

Figure 12 Supported discharge within hours

The intermediate care team had to tick these time focused boxes on first meeting the patient and then again on discharging them. They therefore have a real-time understanding of how well they were meeting their targets. They recorded the time they got the referral, the time they saw the person and other time points throughout their intervention. Their care and assessments were always punctuated by a look at the clock and the scribble of the time on a post-it. Not only were they under pressure to do their work within specific time frames, they also had to prove that fact using the 'monitoring form' which only recorded success numerically.

In addition to constantly recording their response time, the intermediate care team were under pressure to prioritise ED over the AMU despite covering both clinical areas. The need to prioritise the ED was to ensure that the Trust could prevent patients from "breaching" the four hour target¹⁴. As a result of this, a very busy ED would mean that the patients on the AMU had to wait for the intermediate care team's input. The field note below details an example of this and the intermediate care nurse's reflections on it.

¹⁴Department of Health (2011) *The Operating Framework for the NHS in England 2012/13*. London: HMSO national target for A&E services aims for 95% of patients being seen within 4 hours with fines imposed locally for non-achievement.

The intermediate care nurse then talks about how they prioritise their workload and she shows me the patient list of who is on majors in the ED. All of the patients on that list were highlighted in black except one. Black means they've "breached" their allotted time period. She's not shocked by this list and it seems to be the norm. Many of the patients have been in for over 12 hours. (The list has a timer by each name that indicates how long they have been in the Emergency Department).

Field Notes 15.03.2016

The intermediate care nurse says that admission avoidance always takes precedence over discharge planning when (the hospital) is on black alert¹⁵ and so it's rare that she'll get to AMU before the afternoon. She says ideally they'd have one of their members of staff based on AMU all day but it just doesn't ever happen as they cannot spare the staff.

Field Notes 22.03.2016

The intermediate care nurses discuss their work in ED as admission avoidance and their work on the AMU as discharge planning. Despite being in the hospital, patients in the ED have not yet been admitted hence why their work is labelled admission avoidance, or, preventing admission to the hospital if possible and safe. The distinction between admission avoidance and discharge planning seemed arbitrary as the job role for the intermediate care team was the same for both, making sure that the patient could leave the hospital safely.

The need to prioritise moving patients out of the ED to ensure the four hour target was met not only had repercussions for the intermediate care team, it also had repercussions for the movement of patients in beds in general. In the excerpt from the junior doctors interview below one of the doctors reflects on when their recommendations are either not acknowledged or ignored to an extent that could be detrimental to that patient's care as bed movement is prioritised.

"I think there's a fine line, um you know we've been [under] a lot of pressure in terms of beds and the Trust doesn't always look at the clinical picture despite us telling them. I've had a lot of pressure over nights for example where they've tried to move patients around and it's not necessarily best for elderly patients and I've told them don't move this patient it's not going to be good for them they're elderly, [...] [They

¹⁵ Black alert means that the hospital is operating at maximum capacity with no free space for those expected to enter the hospital.

need] a stable setting where they can get their bearings... I think sometimes the Trust just looks at numbers and I can appreciate the fact that they get fined for [patient's breaching targets such as 4 hours in ED]. It's a delicate balance between numbers, beds and I guess the perfect patient care and that's quite a hard decision to make"

D2 – Junior doctors group interview

This excerpt describes the pressure placed on junior doctors to identify patients to move out of the AMU to make space for patients who need a place to go from the emergency department. He talks about weighing up his clinical understanding of what will be detrimental versus the implicit need for beds and movement. He describes the decision as focussing on "numbers and beds" or "perfect patient care" implying that the two cannot or do not coincide.

In his interview, patient participant Mr Gilo, aptly described the need to find beds and focus on pace as "chomping at the bit".

"... I was visited every day and ... I got the glimmer that I was on my way, uh it was all set in motion, they were all chomping at the bit to get me out of there"

Mr Gilo

The tone of Mr Gilo's quotation is interesting. Initially he uses "glimmer" implying hopefulness that he was approaching being able to be discharged having been visited every day. From here, it appears that his discharge was expedited very quickly. This change of pace is evident from his hesitation half way through. Despite hinting that he was hopeful about going home, the choice of the phrase "chomping at the bit" can be interpreted as aggressive with impatient connotations. His quotation indicates how the urgent need for beds is felt by all those on the unit including patients. The experience is not isolated to health professionals.

In summary, the pace priority in the unit was felt by patients and health professionals alike. The AMU clearly set this expectation to patients as soon as they arrived. The success of the unit was measured and judged by pace focussed outcomes. For the ED, that everyone is assessed within 4 hours and for the intermediate care nurses that they respond to referrals within 60minutes and they aim to discharge people within 48 hours. The processes of prioritising the ED to prevent breaches meant that the system got stuck. In focussing on ED, they then had to find beds for them, rather than focussing elsewhere and freeing beds up in advance. Health professionals were forced to watch the clock in their practice, to either ensure they meet KPIs or be aware of how close a person was to breaching in ED. There were undertones throughout that health professional recommendations would be ignored in

favour of bed movement. The search for beds has aggressive undertones in the experiences of those within it as the Trust “chomps at the bit” and puts pressure on this continuous activity.

6.3.3 Disjointed processes

Despite this pace priority and the constant need to create space in the AMU for patients in the ED, the processes within the AMU were not conducive to effective and efficient movement of patients through the system. Ineffective daily processes were especially frustrating for health professionals. The code ‘disjointed processes’ was the most frequently used code (N=26) across the entire data highlighting the prevalence of the issue.

One such factor in these disjointed processes were the constant interruptions while the professionals tried to complete their day to day tasks. In the field, it was difficult to keep up with the many thought processes that were required at any one time as professionals were often having multiple conversations or trying to do two tasks at once. The field note below, from time spent with the intermediate care nurse, gives an example of these interruptions.

While she’s on the computer there are lots of other things going on. A patient in the other bay falls over and she jumps up to help them and then comes back. The health care support worker and the nurses chat to the consultant about other patients. One of the health care support workers asks “can someone print me off a sticker for (patient A)” and the intermediate care nurse offers to do it, although she is obliged to as she is working on the computer. While this is all happening one of her two bleeps goes off. She calls the number and it’s someone from AMU. She then scribbles down a message for herself “Red bed 4” alongside the time and puts that in her pocket...

Just as she finishes copying down the information. Another of her bleeps goes off. She sighs and returns the call, its majors¹⁶. “This is why you can’t get anything done” she says.

Field Note 15.03.2016

This field note excerpt highlights the types of interruptions that occur. Health professionals have to be ready to deal with the unexpected (such as a fall in the instance above). In this instance, the

¹⁶ Majors refers to the area of ED that deals with patients who have been triaged as needing high level medical support. The minors ward refers to those that don’t need as high level medical support – often in minors there are no beds as the patients can manage in a waiting room-style area whereas in Majors they have trolleys.

intermediate care nurse was trying to complete work on the only computer available that was able to print stickers. Stickers are important because they carry all of the crucial information required for blood tests, investigations and referrals (date of birth, NHS number, hospital number, name, address). It is then inevitable that sitting at this desk involves being asked to print stickers at any time. The alternative is to find another computer, of which there are very few and they are all in demand. Taking up a computer on the unit to complete clinical work meant also adopting the temporary role of ward clerk or administrative support concurrently.

More than the distractions and interruptions from the hospital environment, phones and printers, the staff also had a system designed for the sole purpose of interrupting – the bleep system¹⁷. When a health care professional's bleep goes off on the unit it interferes with the intended persons' thought process as well as the thought processes of all those who carry bleeps around them. A wave of people checking their bleeps erupts as soon as the high pitched "beep beep" sounds.

There were other aspects of the way in which work was carried out that seemed counterintuitive to aims of pace, efficiency and productivity and instead were symptoms of the chaotic roles that health professionals tried to maintain and negotiate. From people scribbling bits of information down on scrap pieces of paper in order to remember all the information required to misinformation being handed over from team to team. The field note below demonstrates an instance where miscommunication led to an inappropriate discharge plan for an issue that could have been solved if there had been adequate service provision in place.

As I listen to the intermediate care nurse on the phone I realise that the patient who only needed a commode to go home, who we saw in minors earlier, has been wheeled in to the Observation Unit. I overhear the nurse give a hand over to the Observation Unit nurse saying that the patient needs an overnight stay because the intermediate care team say she needs a commode and her daughter couldn't pick it up in time before the British Red Cross¹⁸ shut at 12...

Field Notes 22.03.2016

¹⁷ As is usual in an NHS clinical environment, the majority of the health care professionals all carry bleeps or pagers. Sometimes they're needed for an emergency response. Other times they are needed for an urgent enquiry or referral. Sometimes they are used for much less urgent queries such as asking for some information about a service, clarifying something someone has written in the notes, ascertaining how busy someone is or seeing if someone wants to go for lunch.

¹⁸ Charity the British Red Cross British Red Cross (2017) *Mobility Aids*. Available from <http://www.redcross.org.uk/en/What-we-do/Health-and-social-care/Independent-living/Mobility-aids> [Accessed 16th October 2017] run schemes across the country for the provision of mobility and toileting aids that can be borrowed free of charge when needed.

The nurse I was job shadowing in this instance had been on the phone when this patient was wheeled through. I had been privy to many conversations that day about bed capacity and was aware that awaiting a commode is not a good reason to occupy a hospital bed (see Figure 10 Welcome to the AMU leaflet). The way the information was being communicated from the 'minors' nurse to the 'Observation Unit' nurse put the "blame" (if there was going to be any) with the intermediate care team. On hearing this, the intermediate care nurse arranged for an occupational therapist from one of the wards to provide a commode for the patient "as a favour". It is not unusual for people with mobility problems, especially temporary ones as this patient's was, to require items of equipment such as a commode in order to go home safely. Yet, there was no process in place to ensure these were available to facilitate discharge except for asking family members to get them from the Red Cross before lunch time.

As well as a lack of process for some routine issues like equipment need¹⁹, other aspects of care appeared disorganised too.

D4: I think sometimes it gets a bit out of control like I've had patients before that are ready to go home but for some reason have been seen by [intermediate care team] and had transport organised and everything and they weren't actually medically fit for discharge, um I don't think it happens very often but I think sometimes people slip through the gap

Junior Doctors Group Interview

In this excerpt the communication between the medical team and the rest of the team on the AMU has been insufficient. The other team members have started the process of organising a discharge for a patient who is not yet medically fit enough to be at home. As a result, the junior doctor has had to stop the plan, wasting the time and effort that had been put into arranging this discharge.

One of the frequently observed issues pertaining to disjointed processes was related to communication and the transfer of information to people, teams and those in community teams. One result of poor communication was duplication whereby the same information was being obtained by different teams and people. Below is a key example;

Just as the Physiotherapist supervises the patient back to her chair and says goodbye, a member of the intermediate care team comes to see the same patient. "I'm going to

¹⁹ The provision of community equipment and adaptations is a known cause of discharge problems N.I.C.E. (2015) *Transition between inpatient hospital settings and community or care home settings for adults with social care needs*. London: NICE.

come and see you in a moment” she calls over to the patient while putting her file on to the nursing station desk. “I’ve just walked her” says the Physiotherapist, “She’s steady, well set up at home, [four times a day] package of care, downstairs set up...” “Oh ok,” the intermediate care nurse says and flicks through the notes, “says community bed²⁰ here” the Physiotherapist doesn’t seem to understand why that may be and thinks she could go home.

The intermediate care nurse goes over to see the patient and pulls the curtains behind her. I sit at the nursing station alongside the Physiotherapist while she’s writing her notes. I hear the intermediate care nurse have almost exactly the same conversation as the Physiotherapist with the patient and there’s no acknowledgement from anyone else around that this repetition (in such close proximity) is out of the ordinary or inappropriate. The physiotherapist said nothing, neither did the ward nurse or the junior doctor.

[...]

Once they’ve finished the conversation, the nurse comes over to the nursing station to speak to the staff nurse and the doctor. “She can go home. She has her son living with her doing domestic tasks and a package of care to help with everything else. Physio are happy with her walking so we need the TTOs [*To Take Out Medications*]”. “TTOs, right” says the doctor and scribbles it on a piece of paper.

Field Notes 24.03.2016

It was apparent that this repetition undermined the work of both the intermediate care nurse and the physiotherapist. It appeared that only one of them needed to have seen this lady as they both came to the same conclusions by doing similar assessments. The lack of questioning of this practice in the moment was also notable indicating that this is likely to be a regular occurrence, common practice and ingrained in the AMU’s usual culture. From the perspective of the intermediate care nurse and the physiotherapist it is likely that they both had open referrals for this lady and therefore both had a duty of care to ensure she was safe to go home. However, within this model of practice favouring professional silos over team-working, the assessment process was disjointed and the patient experience was repetitive.

²⁰ The term ‘community bed’ could refer to any inpatient bed funded by the community NHS trusts or social services, this could include a temporary nursing home stay where further assessment of care need is made or for a period of convalescence or a bed in a rehabilitation ward in a community hospital for those who have further rehabilitation goals.

Chapter 6

Within this section, three examples of disjointed processes have been identified in interviews and field notes. The constant interruptions of health care professionals, poor communication between the team and repetitive assessments across different professional groups. With better or clearer communication and team-working it may be that these issues would not arise. Despite the lack of time on the unit, all of these disjointed processes took up time and did not fit with the pace agenda.

6.3.4 Environment not fit for purpose

In addition to disjointed processes, obstacles resultant of the hospital environment also delayed efficiency on the unit. For example, the intermediate care team occupied an office that was previously a reception desk.

The community team's office is the old AMU reception and it looks like a reception desk... as they work away on their computers people constantly ask for directions and information. More interruptions.

Field Notes 15.03.16

The old reception area office not only adds to the interruptions that stop the nurses from working effectively, it also adds confusion and frustration for relatives and patients trying to negotiate their way around the AMU.

Another example of the environment limiting the care received by patients can be seen in the field note below where an incident had the potential to become a serious patient safety concern. Here, a cubicle room²¹ that appeared to "float" between Blue bay and the ED (see Appendix U) escaped the fields of responsibility of both the Blue bay team and the ED team.

We then go to visit the last patient of the day. She's in a cubicle that is attached to ED Majors but for some reason, that isn't clear to me or the intermediate care nurse, is being managed by AMU Blue. Apparently, it wasn't that clear to the Blue AMU team either. They hadn't known to organise her breakfast for example. She's been here for two days without a medical team reviewing her.

Field Notes 22.03.2016

²¹ Single rooms in cubicles differ to the normal beds around the bay on the AMU. They often have their own bathroom and usually have the door shut at all times. They are reserved for those patients who have contagious infections or diseases to stop them from spreading to other patients on the unit. Sometimes these rooms are also used for those who would benefit from more privacy, such as those receiving end of life care.

Luckily for this patient the doctor covering Blue that day noticed that no one had been seeing her and took responsibility for her care on the day we saw her. He then co-ordinated everything and escalated the issue. He was frustrated, not only that she had been left and received inadequate care, but also because she didn't appear to need the bed she was in anymore and it could have been put to better use.

On this occasion the environment of the AMU was not at fault. It is necessary to have a cubicle within which patients who have infectious diseases can be treated. But in this instance the management of the environment had failed the patient. The idea of "lending" this bed space to the Blue team may have made sense to the bed manager and the person the manager agreed it with but two changes of shifts later it can be lost. It is unusual for Blue bay team to look after the side room and as such, they didn't. For the doctor who realised the error, his work was made much more complicated and convoluted. This is also an example of the AMU and those working within it having difficulty adapting to unusual situations or patients and another example of when communication of crucial messages has not been efficient.

In addition to the environment management being poor, a lack quiet spaces was raised by the nurses during their group interview. The AMU has a number of clinic rooms, a meeting/seminar room and a family room/store room but it appears that these spaces are not easily accessed during the day for important or sensitive discussions.

N2: if the discussions were in an environment where there isn't a great deal of noise going on around [the patient and/or relative] so they're the focus. There aren't 3 million people interrupting the conversation and wondering past,[...] I sometimes think that there's so much going on in those rooms I think they're very I think they do very well in spite of it

Nursing Group Interview

Here, the nurse describes how the busyness and noise of the unit are not conducive to in-depth discussions about discharge or care. They admit that when discussions are had by the bedside, on the unit, the older people are not always the main focus and instead the distractions of the unit's busyness are rife. The extent of this was evident on one occasion in the field note below where the noise and busyness was even more amplified by an unexpected fire alarm sounding.

The intermediate care nurse talks to the patient's son in law who tells her that he feels the patient's confusion and her pain is worse. The intermediate care nurse sees this as evidence for why this patient requires an admission. During the conversation, the fire alarm goes off. My immediate thought is that we have to leave and help to get the

patients out but the rest of the staff carry on as normal. One nurse goes around shutting the door to all of the bays. This doesn't help the patient who is confused and on the commode alone or the patient's husband who is stranded in the middle of the bay, very confused and sat on a porters' chair. The intermediate care nurse doesn't break from her conversation with the family member. She just shouts louder so that she can be heard over the alarm. She doesn't explain what is happening, just continues as normal. That behaviour makes me panic, let alone the son-in-law or the patient on the commode. Thankfully, the fire alarm stops and message spreads quickly that someone was just trying to smoke in the toilet...

Field Notes 22.03.2016

During this field note it seems evident that the staff on the unit are so used to the noises and huge interruptions in their everyday jobs that they don't think to explain them to others. This conversation was quite serious and emotional for the patient's relative who was trying to explain that the patient wasn't back to her normal self and that they as a family needed to help. The information obtained in this conversation will be crucial to the next part of the patient's journey in the hospital. In an ideal world, this moment is a good example of a time when the conversation would have been better handled or more comfortable in a different, more private environment. Instead it took place with the patient on a commode, behind a curtain. The son and nurse stood face to face just outside of the curtain and the patient's husband sat aimlessly in the middle of the bay on a porters' chair. It often felt like the opportunities for these such discussions and assessments were "now or never" in nature and not housed within the most appropriate, dignified or comfortable environment

6.3.5 The pace focussed environment in summary

This section has dealt with the first objective of this study; to understand the context of the AMU. The urgent need to focus on pace is obvious to all on the unit. The AMU is on the front line in terms of the pressure to ensure the Trust meets ED's four hour target, avoids breaches and the associated financial penalty. Firstly, the AMU and the patients on it often get deprioritised in favour of those on the ED. Then, the AMU is under pressure when there are not enough beds for those who need them and need to move from the ED. Despite this pressure for pace, the processes on the unit are disjointed and the environment is not conducive to efficiency and uncompromised quality care. The impact of this is explored in the next part of this chapter.

6.4 Impact of the Acute Medical Unit context on those within it

The context of the AMU was described in the previous section as being pace focussed with disjointed processes. Inevitably, the way the AMU was organised and operates impacted the experiences of those within it; health professionals, patients and relatives. As per the second objective in this study this section explores these impacts. It is important to understand these impacts as they have influence on the way that discharge decisions are made. This section begins with the impact on older people as patients.

6.4.1 Older people feeling guilty and illegitimate as patients in the pace-focussed environment

Older people as patients were acutely aware of the fast paced environment of the AMU. This awareness was manifest in the way they acted and constructed themselves as patients. In particular, patients reported a large sense of guilt at being on the unit in the first place. The concept of the guilty patient featured heavily in the experiences of older people on the AMU. Often the patients disclosed their guilt during interview as a way of demonstrating their understanding of the pressures on the NHS generally, or to show how they were trying to help where possible and how aware they were of the fact that they were taking up space. Mrs South described her predicament below.

“but when it was in the [newspaper] how busy they were, not to go there if you can help it. And certainly not with a cold or anything like that, go and see your GP, so I never intended to go there at all,”

Mrs South

In this excerpt Mrs South demonstrates that she understands when not to use the hospital to get help. In her case she had called the GP to visit and the GP had made the decision for her to go to the AMU. She frequently discussed this as a way to justify her attendance to the AMU. She wanted it to be clear that she knew not to go for any non-urgent need and that it was not her choice to go in the first place. In doing so, she seeks to legitimise her AMU attendance.

Not only did patients express guilt by feeling the need to justify their attendance on the AMU they also exhibited guilt in relation to their use of resources. Frequently in interviews, participants referred to the time, cost and food that they were using whilst being a patient.

“I thought, I don’t want to waste their time you know, using their foods, they even came round and asked me what I wanted for lunch, I said “I won’t be here for lunch”

Mr Smith

In a similar tone to the previous quotation from Mrs South, Mr Smith attempts to distance himself from the need to rely on hospital resources. In his interview he makes it clear he did not want to use the hospital's time nor their food and was motivated to ensure that he did not have to. For Mr Smith, not only is this a disclosure of not wanting to take up space on the AMU but also indicates an attempt to take control of the situation, "I won't be here for lunch". He does not want to be dependent on the unit. Mr Smith went out of his way to get discharged the day after his admission. To his wife's surprise, Mr Smith turned up on her door step, exhausted, having got a bus with no coat from the hospital to home and having told the hospital not to worry about contacting his wife to let her know. For Mr Smith, it appeared that he was anxious to avoid being a patient and ask for help or support. He felt that his presence on the unit would be a waste of the time and resources of the staff on the AMU and in the process took back control and reaffirmed his independence. The busyness of the unit was so evident to patients that they tried to avoid adding themselves to the workload.

Other patients were much less able to take control of the situation than Mr Smith. However, the self-awareness evident in Mr Smith's quotation above was still evident in the other patients' experiences too. During observations patients' need to apologise, when their ailments and health were not allowing them to fit within the fast paced discharge culture of the unit was frequent. This is evident from the field note below during Physiotherapy intervention.

Physio: can you march on the spot?

Patient: I can't sorry... it's too painful

Physio: stand up straight for me

Patient: I can't do too much of it today sorry

Physio: alright

The patient then sat back in the chair

Patient: I'm sorry

Physio: that's ok I just needed to see what was going on

Patient: yeah I'm getting new tablets today

Physio: well hopefully they'll work

Patient: I'm sorry

Physio: don't say sorry, no need to be sorry

Patient: My pesky knee

Field Notes 24.03.2016

In the field note extract above, the patient repeats "I'm sorry" multiple times. She is unable to comply with the physiotherapist's plan for that session. She is limited by pain, something she's not in control of, but is aware that it is not the outcome that the physiotherapist would have wanted. The physiotherapist in this interaction did nothing verbally or nonverbally that was indicative of anger or frustration and yet the patient clearly felt she needed to apologise for her body and the way it was letting them both down. The apologies are reinforced as the physiotherapist continues to try and progress the session following her agenda to get the most out of an assessment (in-keeping with the unit's pace focus) despite the patient informing her at the start that she wouldn't be able to do it.

In addition to apologising, patients often sought to observe their fellow patients and locate themselves with these comparisons as if to work out whether they warranted their place on the unit or not. Mr Parrot discussed this in his interview below;

"There's some very ill people in there, if I was like that, I wouldn't mind it but you know you're thinking well what am I doing in here? I'm ok."

Mr Parrot

Mr Parrot discusses how he did not seem as unwell as those around him and he therefore worried that he should not have been there. Not only did the pace focus serve to make patients feel guilty and illegitimate as patients that will add to the busyness, but also the acuity and how unwell some other patients were in comparison reinforced this. Consistently, the patients wished to make observations such as these clear in the interview. They wanted it to be known that they knew they were not as ill as other people, that they knew they were taking up space, that they were eating food and using health professionals' time. The quotation from Mrs Peach's interview illustrates this well.

"You know what I mean, I, as I sit in that hospital bed and I look round and I think "Oh I feel so awful taking a bed here""

Mrs Peach

It seemed that the early mention of discharge led to patients analysing their position on the unit. As discharge increasingly got discussed, the patients appeared to conclude that they were no

longer legitimate patients on the unit and looked around them for comparisons. They then feared they were wasting time and resources when discharge did not materialise.

The nurses were aware of this effect too. In their group interview, they identified that many patients feel like a nuisance. In particular they reflected on the fact that the short term nature of their stay added to that sense of being a nuisance. In the nurses' experience, patients equated a short stay to a lack of serious need and therefore minimal justification for their service need.

“That’s the worry is that some of them, particularly the older ones, think that because they’ve only been in a little while, they’ve been a nuisance, they’ve not been taken seriously.”

Group Interview – Nurses

The nurses imply that the short stay leads the patients to believe they may not have needed to come to the hospital in the first place. If your length of stay is much longer it is much easier to explain or justify your identity of a ‘patient’ or of an ‘unwell’ person. Drawing together the experiences of guilt, the need to apologise for one’s own body, the need to locate oneself as more or less unwell than other patients and the acknowledgement from nurses that patients often feel a burden it appears that a short stay brings with it a sense of discomfort and illegitimacy.

The older people in this study also looked to the staff and the staff experience too. The interview questions (Appendix K) did not directly ask about how the staff appeared or what the unit felt like, and yet participants frequently provided observations surrounding what it must be like for staff to work on the unit. Participants continually mentioned how short staffed the unit appeared and how short of time the nurses were which inevitably confounded any feeling of minimising their own needs and support they required.

“well exactly, she was running around trying to get this trying to get that and must be frustrating for them sometimes, there was plenty of people in there”

Mr Smith

“I just don’t know how they do their job I really don’t”

Mrs Adams

“nursing staff particularly and the doctors are so overworked, it’s just not believable ... time [in] motion study as we knew it as youngsters would go into overdrive”

Mrs Norway

It appeared that as awareness of busyness grew, so did guilt. In addition to distancing themselves from those in need of staff time and attention they also sought to distance themselves from those

patients who they perceived to be demanding staff time and attention unjustifiably. In their interview, Mrs Adams' and her daughter discussed "demanding" patients.

Mrs Adams' daughter: ... but then on the other hand you do get the demanding people who take the doctors and nurses away because they want

Mrs Adams: yeah they're demanding and so they do it to keep them quiet

Mrs Adams' and daughter interview

By comparison to the "demanding" patients that occupied staff time, the patients in this study appeared to seek to be better patients, good patients and helpful patients. Mrs Kelly and Mrs Adams both discussed how they tried to be helpful to the health professionals.

"so while I was sitting there dressed I stripped my own bed and left it ready for the girls just to take away,"

Mrs Kelly

"I feel as though I'm a bit of a busy body but the nurses seem to appreciate it sometimes you know you got a somebody in the bed next to you and they gets quite agitated but if you sort of go to them and ask them what's the matter and is there anything you can do , because if the nurses are busy sometimes they need some little thing you know there was one lady next to me bless her and she said "oh my feet are so cold" she said "they're freezing cold" you know and I said to her "oh I've got a spare pair of bedsocks let's get them out""

Mrs Adams

For both women, they observed a person or task that needed attention, for Mrs Adams a lady who was cold and for Mrs Kelly a bed that needed to be made. In response to this unmet need and the acknowledgement of how busy the staff were, coupled with the patients actively seeking to minimise their own needs, both women sought to appear helpful and be "good patients". Their quotations portray an "all hands on deck" sense on the unit.

Within the pace focussed, busy, short staffed context of the acute medical unit a sense of guilt was consistent across older people's experiences. Patients demonstrated the need to make this guilt and their awareness of busyness evident in their interviews. This served to both distance themselves from the most unwell or needy patients but also to legitimise their experience as patients on the acute medical unit. Patients were also self-aware in acknowledging when they did not fit within the usual routine or rhythm of the unit. In response to this they apologised for their bodies letting them down. The nurses on the unit summarised that a short stay can often

encourage patients to feel “a nuisance” and not entitled to the care and resource of a hospital stay. In reality, all those in the study had very legitimate medical reasons to be admitted to the AMU and appeared much more unwell than their self-assessments portrayed.

6.4.2 Relatives negotiating a confusing environment

The environment of the AMU was fundamentally confusing to negotiate. To most relatives and patients the AMU was a new and unfamiliar environment and this confusion was exacerbated by the aforementioned issues of disjointed processes and unfit for purpose environments. It was relatives who often had to negotiate this environment as they sought to visit patients, meet health professionals and assist or manage the co-ordination of a person’s care or discharge.

Despite the intermediate care team bridging the gap between community services and the acute hospital and providing clarity regarding the community provision for the rest of the AMU team, the problem of different postcodes and different services was not lost on the patients and their families who also had to try and understand them. Mr Gilo’s wife discussed some of the confusion she faced with regard to getting a social services assessment following hospital discharge.

“Um I’ve got, she gave me some numbers didn’t she, what was that lady from? She was from the carer side of things but she was in [the city] but we don’t come under [the city] because we’re in [out of area]. She gave me the number to phone and I phoned them up and she was um, I thought she was quite rude actually and I said to her, “we didn’t ask for your help, we were told to phone you to get help because they think we needed help” and she went through all these questions and I said “no we can do this and we can do that” so she said “well what do you want us for?” and I thought well what did they give me your number for then? Just cos we can get in the bath and wash and dress ourselves and feed ourselves I mean I didn’t ask them to come to us and then the other lady said, if you go to the red cross, they’re the best ones because you don’t have to buy things off them they will loan it to you, but I mean, what do we want? We don’t want it do we?”

Mr & Mrs Gilo’s interview

Although Mr Gilo in this instance was deemed safe to go home from the AMU, the staff discharging him felt the need to signpost his wife to social services to ensure they were able to get support should they need it. In doing so, however, they added to their confusion. Mr Gilo’s wife followed their instructions only to be told that she and her husband were “too good” to receive care. She did not appear to have any more specific idea on what the

professionals felt they needed assistance with. As such, if a need had been identified it was then not met. Mr Gilo's wife was also provided with the phone number of the wrong local authority in the first instance. All of these difficulties, just to be told that they didn't need any support, meant wasted time and pointless confusion for Mr Gilo's wife.

The confusion was not unique to the time after discharge. During their stay, patients appeared to find their relatives particularly helpful for being "a second pair of ears" for some of the confusing information regarding their health that they received. Mr Parrot explained how he relies on his wife in his interview.

Mr Parrot: I don't retain anything that doctors tell me because I just rely on her

Mr Parrot interview

This was not uncommon amongst the patient participants. The level of communication bridging between patient and health professionals was even more obvious in the field notes. The field-note below indicates how the patients' relatives almost revisited and revised conversations that the health professionals had had when they had gone.

While the intermediate care nurse went to fetch the porters' chair, I heard the family talking to the patient...They were repeating what the nurse had said to the patient, translating it, checking her understanding and reminding her of how her symptoms had been in the weeks leading up to the admission. They also almost corrected the patient for not quite giving the correct picture to the nurse about how she had been managing.

Field Note 15.03.2015

The field note above indicates how relatives are often expert in how the patient manages at home normally. They act as a translator when conversations with health professionals are confusing and attempt to aid in the patient's understanding. Where the intermediate care nurse did not appear to have time to check the patient's understanding, the family were there to do it instead. This did however make many relatives and patients with relatives wonder how those without relatives managed a hospital admission. This is evident from the interview below with Mrs Adams after she had reflected on how her daughter had helped her through her discharge. However, a lack of family members was never mentioned as an issue in the interviews of those without relatives.

Mrs Adams: We're very very lucky with family around

Mrs Adams' interview

In summary, relatives were an asset to patients in the negotiation of the confusing environment but they too did not find it easy to do so. When family members were present they were required to bridge the communication, be an extra pair of ears, translate things and remember things that may have otherwise been forgotten. Relatives felt this was integral and felt without their presence crucial information would have been lost within the chaos of the AMU.

6.4.3 Dissatisfaction of those working on the AMU

“It’s the same battle and same questions every day,” says the consultant...

Field Notes – 05.04.2016

The disjointed processes, busyness and pace focus often led to dissatisfied and disempowered health professionals. The quotation above from one of the acute medical consultants indicated how the frustrations and everyday battles felt continuous and never-ending. ‘Staff moans and groans’ was one of the most frequently used codes across the data – particularly within field notes. What seemed to have the greatest influence on the job satisfaction and professionalism of the health professionals was their perceived voiceless-ness and powerlessness against the institution. They othered the institution in the way they spoke of “them” and “the Trust” as though the individual health professionals were a separate entity to the organisation. The staff felt that if they made a plan or decision it didn’t mean it would be abided by. This disempowerment was a learnt reaction following previous instances of senior management on the unit overriding their or others’ decisions. The field note below describes a quotation from one of the intermediate care nurses.

The nurse then goes on to say “but sometimes we decide not to send someone home at night but just cos we decide that it doesn’t mean that the hospital agree.”

Field Notes – 15.03.2016

“The hospital”, “the Trust” and “them” never appeared to have a face or a name or one person who represented their views. But this faceless character on the AMU was omnipresent and occupied a large part of the narratives of those who worked on the AMU. Apart from overriding clinical decisions such as discharge or bed movement, the power of “the Trust” was also felt as a result of the change initiatives that often impacted on the work of those on the AMU. One such team that was especially affected by change during the fieldwork were the intermediate care team. They seemed the most voiceless and disempowered of all of the professional groups on the unit – as the field note below indicates.

The intermediate care team's day is plagued with politics, staffing levels and a feeling of not really being appreciated [...] They're under examination at the moment as there is a new plan for the merging of two teams. The second team is new and has less history than the intermediate care team (and has less experienced staff) but it better fits the current priorities of the Trust. The new team has [...] realised that they'd benefit from knowing what the intermediate care nurses know. They now have to share an office and today the sign on their office door got taken down and replaced by a new one where the intermediate care team's name was written underneath the new team's name. It felt very symbolic and put everyone in the community team in a bad mood for the rest of the afternoon. The intermediate care nurses knew this was happening but they don't seem to have had an opportunity to influence it. This merger is happening under their feet and continues to happen regardless of how hard they stamp them.

Field Notes – 22.03.2016

This reflection at the end of a day of fieldwork shadowing the intermediate care team provides an example of the kinds of changes that are implemented in which professionals felt unable to influence. The nurses felt quite strongly that the change that was occurring was not going to make a difference. It felt to them that this new team was encroaching on their remit and because they were a new initiative were being heralded for achieving similar targets that they had already been meeting. There had appeared to be a complete lack of consultation with them. The intermediate care team had felt threatened by this new team and there was no evidence of a collaboration between the two teams. The nurses made their feelings of being fed up and undervalued very clear during field work.

As well as changes threatening the satisfaction of health professionals, the environment also does not serve to make them feel like a valued component of the AMU team. In the following field note, the intermediate care nurses discuss their dissatisfaction around their environment and the sense that it will never be a priority of the hospital to fix it.

The intermediate care nurse tells me that [their office] was measured up a few months ago by the company that run the maintenance of the hospital so that it could be made into a more workable space for them. The nurse adds cynically, "to make us feel valued". The lady from the Red Cross who also sits in this office laughs out loud at that. The nurse says "she's laughing because we all know it's just never going to happen".

Field Notes 15.03.16

In this excerpt the intermediate care nurses describe what they perceive to be a tokenistic “measuring up” of their office. The Trust has acknowledged that it is not a suitable working environment and yet, despite this obvious effort to get it fixed the nurses are not expecting the issue to be resolved. In fact, they see it as an obvious and superficial move to stop them from complaining about it and are cynical about the organisation’s motivations for taking this step. They appear used to this pattern of events and it is evident they have experienced similar before. They have a preconceived notion of how it will pan out.

What heightens the discontent surrounding such changes was the apparent lack of sustainability of some of the previous changes that the Trust has tried. In the nursing group interview one nurse listed off some of the initiatives and changes that had been made over the years.

“we’ve experimented with things over the years on the unit and ... we had someone who was a designated discharge planner at one point which worked very well but you know, times moved on so they tried, ... at one point ... a nurse who was solely seeing all our patients with mental health issues so we didn’t have to and again it helped but findings are an issue and these things were never... weren’t allowed to stay.”

N2 – nursing focus group

Again, the responsibility for the decision to not continue with such initiatives is placed with the “other”, the faceless, nameless “Trust” and yet the nurses could easily describe the benefits of each initiative. Moreover, the volume of temporary ideas and changes added to discontent and confusion and served to become another “everyday battle” to contend with.

On top of feeling powerless to influence, the health professionals had to adapt to the norms of their work and assessments to fit with the pace focus of the environment. For example, it was clear that they had honed the skill of keeping patients and their discussions on track to ensure they were kept within their short allotted time frame. This is exemplified in the interaction in the field note below between a patient and an intermediate care nurse discussing discharge.

She talks to the patient about potentially having a pendant alarm²² fitted. The patient then explains to the nurse that in her block of flats they always have to have owner’s meetings where they all decide together what needs to be done and what services they need. “They’re all a bunch of old people who have more money than me!” says

²² A pendant alarm is worn around the neck or around the wrist. It consists of a button on a pendant on a string. The idea is that if a person falls and cannot get up they press the button to call for help.

the patient “so I may bring up a pendant alarm with them”. The nurse says “it doesn’t have to be one that everyone gets, it can just be a personal one” but the patient doesn’t really register that and continues to explain about the politics in her flat building. “I’ll give you the information anyway” interrupts the nurse as she jots things down on a piece of paper and moves on with her discussions.

Field Notes – 15.03.2016

In this instance the information that is not deemed important (the politics of this patient’s block of flats) goes unacknowledged in the conversation. No response given and no normal conversational filler that acknowledge the patient’s experiences and personhood. The nurse continues with only task-orientated discussions. Now the nurse is able to document that she saw a need for a pendant alarm and gave the adequate information. Her duty of care is now complete. However she has not captured the intricacies or the complexities surrounding the pendant alarm for this patient, the likelihood of this patient organising a pendant alarm is slim, despite the apparent need. However, it does not appear that the nurse has time to sit down, unpick the problem, give advice or help to problem solve it.

On some occasions however, there was a need to go against the task focussed pace focussed approach. In their group interview the nursing staff reflected on their need to rebel against the ingrained pace focus in their remit of patient advocates.

N2: “...we are professionals and most of us do know what we’re doing... we don’t really ... give it a thought. You know that they’re chomping at the bit for the beds but you know ... a decision to not discharge is not ... compounded by [that]”

Nursing Group Interview

Here, nurse 2 who usually confidently answers questions during the group interview, provides a more hesitant explanation that she does not let the need for beds infiltrate her judgement on whether someone can go home or not. She also pointed out with some concerning uncertainty that there may be nurses that don’t “know what they’re doing”. In addition her wealth of experience is likely to make her more confident to assert her own assessment. The quotation above leaves doubt regarding more junior, less confident nurses who also have to deal with those “chomping at the bit” and that the outcome may be different for those being looked after by less experienced nurses.

In summary, the everyday battles faced by health professionals during their day to day work felt plentiful. As such, their job satisfaction and morale appeared low. In the narratives of health

professionals on the unit those with power to influence, “the Trust”, “the hospital” and “them” become other as health professionals distance themselves from the acute medical unit’s organisation and attribute blame for things not going well or to plan. Changes were occurring on the unit, but rather than being symbolic of new and better ways of working, new initiatives felt like just another battle in a confusing environment, any change would likely be temporary and rather than fix a problem induce further change and further confusion.

6.4.4 Summary of the impact of the pace-focussed acute medical unit context

This section has explored the findings related the second objective of this study to understand the impact of the AMU context on those within it. The busy, pace focussed, disjointed AMU had a great impact on those within it. Patients saw the busyness and felt guilty for being there. Early discussion about discharge, very unwell neighbouring patients and demanding patients made patient participants aware of their own legitimacy for being there and they endeavoured to distance themselves from this picture. They were apologetic about symptoms that did not allow them to fit within the pace focus. For relatives the disjointed processes added confusion as they worked out the systems and processes of the AMU. Older people relied on their relatives to be an extra pair of ears and remember, translate and reiterate the information given by health professionals. For health professionals the culture of the unit was negative. A sense of disempowerment was observed in reaction to a pattern of their recommendations being ignored over the need for beds and a history of changes and initiatives which they were unable to influence and did not last. They located the responsibility for their dissatisfaction and disempowerment with the anonymous Trust and organisation. The next findings chapter will address the research objectives related to the discharge decision specifically.

Chapter 7: The characteristics and impact of current discharge decision-making practices

Building on the contextual findings as detailed in Chapter 6, this chapter provides the findings specific to discharge decision-making processes and practices. Here objectives three and four are met. It is understood that both the context of the AMU and the impact of the context on the experience of all those within it shape how discharge decisions occur. Firstly, the characteristics of discharge decision-making are described including the team roles, approaches and behaviours of discharge decision-making. Then, the impact of these practices and processes on all of those involved is explored including the impact on health professionals, relatives and patients.

7.1 The characteristics of discharge decision-making; roles, approaches and behaviours

Throughout the findings, specific instances of discharge decision discussions were not observed. Decision-making happened in snippets throughout the day often at points when the patient was not present. For those patients for whom discharge had no complications, the medical team determined when they were ready to go home, told them this and if no issues arose, they went home. For those patients for whom discharge was more complicated because they had worries, needs or were off their “baseline²³” and required extra support and intervention, once the medical team determined that they were medically fit for discharge and identified a problem, referrals were sent to the intermediate care team or the physiotherapy team depending on what the problem was. Sometimes the physiotherapists would see people before they were medically fit but those who were due for discharge were priority.

7.1.1 Team roles in discharge decision-making

The different team roles within discharge decision-making were well defined and clear. Figure 13 shows the nursing team’s paperwork regarding discharge. This shows that for a discharge to occur it has to be agreed by the doctor (no specificity on seniority). Then, the senior nurse and the senior house officer have to agree that the discharge will be safe. In practice, this did not appear

²³ Baseline was used on the unit by all the health professionals to mean that they could do and manage things as they were able to before they came into hospital. If they were getting their shopping themselves before, they were at baseline if the professionals could see no reason why they couldn’t do that as soon as they leave hospital.

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to involve much discussion. Instead it was a conversation about whether or not they were safe for discharge that resembled more of a handover of information between medical team and nursing team. In addition, there were rarely “senior” nurses on every bay that would be easily available. The discharge checklist does not refer to any other discharge decision-making processes except for informing the next of kin. This may be an appropriate level of involvement for some family members but does not represent the involvement or shared decision-making with family members that is indicated by policy, as discussed in section 3.5 of this thesis.

Discharge		
Checklist	Date / Time Ward _____	Additional information
Discharge agreed (Dr)		
Has it been agreed with SHO & senior nurse patient is safe to discharge		
Discharge summary complete		
Cannulae removed		
Valuables returned		
Next of Kin informed		
To Take Out (TTO) Drugs requested		
TTO's with patient / carer		
Referral Letters complete		
Package of care	Yes <input type="checkbox"/> N/A <input type="checkbox"/>	
Start date and time if yes	Date: Time:	
Transport	Not required <input type="checkbox"/> Booked <input type="checkbox"/>	
Unified SHA DNACPR Lilac copy with patient	Yes <input type="checkbox"/> N/A <input type="checkbox"/>	
Friends and family feedback given		
Signed Name Date Designation		

Figure 13 Nursing team paperwork - discharge checklist

It was expected that the form (Figure 13) would be signed off by the nurse looking after every patient as they were discharged. It was unclear to me how frequently or how accurately these were completed. The checklist does make clear the nursing team’s role in discharge decision-making. This role is firstly to ensure they feel it is safe and then to organise and co-ordinate the whole process (including the arrangement of ‘to take out’ medications, referral letters and hospital transport).

Despite this being clear, the intermediate care nurses perceived that the AMU nursing team lacked any ownership with regard to discharge planning and decision-making. The excerpt from a field note below indicates their frustrations.

As we sit at the computer the intermediate care nurse tells me again how frustrating she finds the AMU nursing staff. She says they don't take ownership over their patients or have the foresight to think about discharge. She says "they take the easy option all the time", like to keep someone in pads when really she feels they could be assisted to the toilet. She says she doesn't know when discharge planning started to not be the ward nursing staff's role. She says, "why don't they work out what the patient did before and try to emulate it?" She feels patients should be encouraged to be out of bed and walk to the toilet and wear their own clothes but that this just doesn't happen.

Field note – 15.03.2016

Firstly, this excerpt is highly critical of the nursing team and shows a friction in the wider multidisciplinary team. "Taking the easy option" appeared in the narratives of the intermediate care team to mean that the AMU nurses were focussed on doing the quickest, easiest to manage approach to things such as toileting. This observation by the intermediate care team demonstrates a perceived practice by the AMU nurses that involves not having the time to provide the most dignified care. In addition to this, the intermediate care team member's frustration at this shows a discrepancy in the approach and point of view (as well as understanding of the other team's role and pressures). In the current chaotic system – it is easy to identify potential knowledge gaps or practice changes in other people's practice. As both teams work towards the same goal ultimately, the intermediate care team can easily identify how the AMU nurses can do things differently. Yet, this team-working or joint approach is not manifest and the quotation shows a "them and us" culture.

It was the medical team who had the most authority in discharge decision-making. Often referred to by patients and other professionals as the key professional who could make the final decision about going home or not. In her interview, Mrs South was asked "who made the decision for you to go home?"

"It must have been one of the doctors, because a nurse can't do it, cos I said "when can I go?" "Oh we're waiting for the doctor to sign the discharge form""

Mrs South

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Mrs South is clear that only a doctor can agree to discharge and so discharge always had to wait for that. The concept of waiting for a doctor was frequent in the patient's reports of their discharge. The nurses would appear to provide patients with limited to no information on the progress of their discharge and instead would tell them to wait for the doctors. The patients discussed getting vague information from other ward staff and then concrete information (i.e. a yes or a no to going home) once the doctor had seen them. Every interview participant reported having been told to "wait for the doctor".

Patients' interactions with other health professionals are well represented by following field note;

"I want to go home," says the patient, "We'll see what the doctor says" evades the Physiotherapist, "but you're good on your feet so I'm happy with that." "Yes better than yesterday" agrees the patient.

Field Notes 24.03

Here the Physiotherapist evades finding out the status of this patients' plans for discharge and instead urges the patient to wait for the doctor. The "wait for the doctor" message prevails.

The hierarchy for the decision-making was clear to everyone. Patient at the bottom, nurse in the middle and doctor as the final authority. Hierarchy and seniority was crucial even within professional groups too. When asked about their roles in discharge decision-making the junior doctors were confident to say that their role was not to make decisions.

"I think ultimately decision making is left to the seniors, the registrars and consultants. As juniors we gather all the information, we build a picture, we can hint perhaps towards the fact that this person might be able to go home and as much as we want to discharge them we can't necessarily do that because they need a senior review, I mean everyone needs to be seen by a consultant, it's part of hospital protocol..."

D2 – junior doctors interview

They defined their role specifically to inform the decisions made by senior doctors, despite the discharge checklist reporting the safe discharge could be determined by a senior nurse and a senior house officer (that many of them were).

The team roles in discharge were as follows; senior doctors make the decisions, non-medical professionals defer decision-making conversations by waiting for the doctors and referring to the intermediate care team when more complex aspects of the discharge were identified like a need for extra support at home. The physiotherapist was referred to if the patients were off their mobility baseline to establish if they could go home or whether they needed rehabilitation.

7.1.2 Behaviours in discharge decision-making; categorising, escalating and bed seeking

This section describes some of the behaviours that surrounded discharge decision-making. It has already been discussed that the discharge decision was not an event of joint conversation. Instead it occurred in fragments along the process. The behaviour explored in this section, bed seeking, escalating and categorising, were all required to ensure a discharge could be organised. Sometimes these behaviours appeared to be used in the place of discharge decision-making processes or conversations.

7.1.2.1 From “medical” to “discharge ready”; the continual categorisation of patients towards discharge decision-making

In order for patients to be discharged from the AMU a process of categorisation took place. The final categorisation being ‘Discharge Ready’ - the point at which the patient is able to leave the hospital. The ways in which patients were categorised were numerous, some directly associated with discharge and others associated with their medical problems or the reason why discharge was being stopped or hindered.

The categorising of patients as a behaviour on the unit was often broader than discharge decision-making. Some patients were categorised as “nice” patients - the patients that the staff members really enjoyed seeing on the ward. These patients were often discussed with additional, “bless them” or other comments that were not in-keeping with the mostly technical/medical language used day to day. In one example within a field note below indicates how some of this language occurs during normal discussions about plans between professionals.

Intermediate care nurse: “Back at baseline you think?”

Physio: “yeah”

Intermediate care nurse: “She’s quite a good little historian really”

Physio: “Yeah she is”.

Field Notes 24.03.2016

In the interaction above the professionals are trying to ascertain whether the person is close to being able to go home. Here the term “baseline” essentially means “back to normal” or back to the level of ability to manage that they were before they were admitted to hospital. The physiotherapist thinks the lady is “back to baseline” and this appears to have been agreed. But in addition, some extra information is shared. The tone of this appears to be quite patronising to the patient in question with the pre-fix of “good, little” – words that may be more normally

associated with children. “A good little historian²⁴” translates as somebody who can provide a clear picture of how they go about their life, something that most of us would take for granted. The conversation is an agreement on two technical components of that person’s presentation, both of which contribute to establishing the suitability of a discharge; baseline physical ability to manage and cognitive ability to manage. However, the language used can be perceived as inappropriate despite it being indicative of a shared endearment for this patient. Implicit in the statement is that they did not expect this gentleman to be able to recall the information they required – hence it is comment-worthy that he did. This speaks to the inherent assumptions made on the unit with regard to the care of older people which pre-determines them to be of those without agency and capability in the fourth age (as discussed in section 2.2). This is in paradox to notions of involvement and shared decision-making, which cannot be observed if lack of agency is an assumption.

On this theme, this type of language often demonstrated that staff particularly liked a patient or felt particularly sympathetic to a patient, they may receive treatment that goes above and beyond the normal level of care provided. In the interaction observed below, the physiotherapist and the health care support worker discuss their affection for a patient.

“Oh he’s lovely isn’t he?” says the health care support worker, “yeah he’s so sweet” agrees the Physiotherapist. “He’s your little... (makes a cradle action) is he?” asks the Physio, “yeah” replied the health care support worker, “I found him a little hat to wear as I felt he was getting a bit cold... and I’ve lined his Fresubins up ready as he’s lost so much weight.” It’s clear that the health care support worker is really worried about this patient and is taking a lot of pride in making sure he’s well cared for.

Field Notes 24.03.2016

This patient has been categorised as nice or sweet. As such he receives extra care. In this instance, the ‘extra’ care the patient receives from the health care support worker seems appropriate. He’s losing weight so she’s given him ‘Fresubins’ (a brand of nutritional milkshakes). He’s cold so she’s found him a hat. But it appears still that this is a special case, not all patients get this level of support on the AMU. It is in contrast to some of the more directive and script-driven interactions that have featured in previous field notes. In addition, on reading this interaction concern is raised

²⁴ “Historian” refers to the fact that the lady can provide up to date and relevant information (or history) about how she manages her life outside of hospital including any medical problems she has, how she does things like cook and clean and what support she has. It refers to what is often termed “history taking” in the healthcare environment be it a medical history, a social history or a psychiatric history.

once again on the appropriateness of the language as it frames the older person as a dependant and child-like.

Being a nice patient or a patient who receives additional or special care is not a clear cut categorisation. Rather, it's a continuum. Most of the other categorisations observed on the unit were more clear-cut and dichotomous, even if this was not reflective of reality. Examples of these were 'mobile' or not and 'medically fit for discharge' or not. Patients were mobile if they were able to move by either walking or getting from their bed to their chair with the same mobility aid that they arrived with. As demonstrated in the below field note excerpt, patients were discussed as "mobile" or "not mobile".

Physiotherapist: "Is bed one mobile?"

AMU nurse: "Yeah"

Physio: "3?"

AMU nurse: "Mobile"

Physio: "7?"

AMU nurse: "No, not mobile"

Physio: "May need to see her then. 9?"

AMU nurse: "Oh he's not very good."

Field Note 24.03

Patients were medically fit for discharge if their medical needs were such that the consultant or registrar deemed them easily managed in the community. The AMU nurses describe this below;

N1: We've been told she's medically fit for discharge, she's had a UTI and she's got chest pain, she doesn't remember falling, she's got an element of dementia (...) her ribs are black, there's no fracture (...) and she is pain. She has a only twice a day package of care and getting her out of bed is hard work, its taking two of us because she is in so much pain. But the medics, as far as they're concerned she's medically fit for discharge and they want community just to assess her.

Nursing Group Interview

In reality, however being "mobile" is not a dichotomy. A person's ability to walk may vary day on day or at different times of the day. It may vary by what they're trying to do, whether they're

getting up to go to the toilet, or if they're getting up to collect their post. Similarly, older people with frailty, as the nurse implies in the quotation above, may not ever feel "medically fit" when they are at home. To a person who is dependent on regular dialysis, home oxygen or a strict and specific medication schedule the concept of "medically fit" may not hold much meaning. Yet, it is discussed frequently, particularly by the medics in the AMU, as a dichotomy.

Appendix V provides a model of what information and sources appeared to be used to determine if someone is discharge ready, as well as the characteristics that health care professions discussed as though they were 'factual assertions' and those which they discussed as though they were more 'qualitative judgements'. The factual assertions were yes and no answers. The qualitative judgements were less clear but in health professional conversations appeared just as a powerful in determining appropriateness for discharge. Determining someone to be safe, sensible and well set up all appeared like concepts difficult to define but were good indicators that a patient would be going home soon – as demonstrated in the field note excerpt below.

The community nurse explained that he was "good", that he was "well set up" and he and his daughter were "sensible". These judgements on people's ability to cope and manage are continually being made by the community nurse and provided reassurance that the discharge was going to be safe.

Field Note 22.03

These kinds of assumptions were often talked about as being "green lights" for discharge. A list of what were observed to be used as "green lights" and "red lights" for a safe discharge within the data is provided in Table 9. Patient preference did not appear to be considered or debated in the same way as the factors in table 9.

Table 9 Green lights and red lights for discharge

Green lights and red lights – HCPs feeling secure in discharge planning	
"Green light" – Reassurance	"Red light" – Concern
Lives with someone else	Lives alone
Has local family	Family far away
Lives in a nursing home, has carers or lives in a warden controlled flat	Lives independent of any external help
Seems "sensible" to health professionals	Health professionals disapprove of decisions/actions
Is cautious of falling or becoming ill – risk averse	Overly confident despite admission – risk taker

Home has previously been “set up” by family, district nurse or OT	No mention of any aids, adaptations, falls alarms or interventions by patient, family or community health professionals.
Steady on feet (with or without aid) in hospital	Unsteady on feet in hospital
No cognitive issues reported or evident	Previous cognitive impairment (current or resolved) regardless of cause

These categorisations served a purpose. The health professionals appeared to need to make these categorisations in order to move the patients through the discharge process as well as to reassure themselves, as illustrated in the field note below:

While she sorts out the paperwork she explains to me a bit more about how she sees her role and decision making about discharge. She explains “when someone can be there it’s a green light for us”. She’s talking about when people live with someone, or live in a nursing or care home or have a package of care or a warden that comes in regularly. “If someone lives on their own, that’s a red light. It’s back up – knowing that someone is there to keep a check on the person”.

Field Note 15.03

Given the pace expectation throughout the unit, the staff need to find aspects of information that helps them reach the conclusion that working towards discharge, as they always are, is the safe thing to do. Particularly, as previous data has shown, in the context of a culture that frames older people as other, dependent and without agency, their worry about patients is a response that the professionals need to manage. This is further explanation for some of the behaviours previously discussed (such as the nurse who didn’t acknowledge that the patient felt she was “back to normal” and continued to complete her assessment just in case). Without these categorisations, patients would have remained in limbo, such as the patient who “*slipped through the net*” previously mentioned. Without dichotomous judgements on non-dichotomous categories movement through the system did not appear possible.

7.1.2.2 When discharge decision-making equates to bed seeking

To patients, an element of “bed seeking” behaviour was observed on the unit. Bed seeking occurred when it was clear that members of staff were looking to clear beds to make space for other patients. Staff were constantly aware of how long patients had been on the unit²⁵. Mrs Adams summarised the bed seeking behaviours in her interview.

²⁵ In a fieldnote 22.03.2017 a consultant said “I’m told there’s three three-dayers on here today”.

“they want the beds so if you’re going home, you know, off you go”

Mrs Adams

Here, Mrs Adams makes simple the issue that as soon as someone is categorised as “discharge ready” the process is expedited rapidly. The only motivator for this quick process that Mrs Adams identifies is the need for beds.

“I think he was after the bed”

Mr Gilo

“I thought they’d be glad to get rid of me, you know, it’s one less patient to bother about”

Mrs South

These excerpts from interviews with patients show how aware they were that health professionals were trying to see to them quickly so that their bed would be free and open for somebody else. They don’t reference any specific conversations with health professionals that explain this to be the case, but the message appears implicit as they observe the pace unfolding for themselves.

In one instance, a patient had felt that the hospital were planning for the person who was coming to take her bed before she’d had chance to leave.

“Once you’re dressed and up ready to go down to discharge lounge, your beds been stripped and being redone and all washed over ready to be made up again because somebody is waiting for it”

Mrs Adams

In this instance Mrs Adams observed them making up her bed as she was about to leave. It is likely that the next person to arrive in Mrs Adams’ bed space would arrive already on a bed and that the health care support workers are on automatic pilot when it came to bed washing and laundry. But still, within the preconception of ‘pace’ that Mrs Adams’ had formulated from her experiences, preparing for the next patient that quickly was logical.

7.1.2.3 When there is a problem in discharge planning; escalate and get back up

If any issues or delays arose as a discharge plan progressed the consistent next step for all health professionals involved was to 'escalate' the issue to those with higher powers such as senior managers in the organisation or in another organisation (such as social services or the community NHS Trust). The requirement for escalation was common and a very well used word on the unit and a mantra of "If in doubt, escalate" was evident. An example of this is in the field note below.

The consultant gets told over the phone that there is a 'discharge to assess'²⁶ bed available but the patient won't be assessed for it until tomorrow. Eyes roll. "Right," says the consultant, "escalate - director level - this is unacceptable." We leave as she phones someone else.

As we return she tells us that she hasn't got very far. She says the residential home with the bed says they don't have transport to come and assess the patient but they do have the bed. The consultant tells us she then spoke to the nurse at the nursing home who was rude and mocked her by saying, "are you going to 'escalate' it are you?!" The consultant is very frustrated and said "of course I'm going to escalate it! This is an acute medicine facility and they've got a bed - what's the problem?!"

Field Note 22.03.2016

As the nursing home nurse's response was "are you going to escalate it?", it is obvious that threats of escalation have been made before and those external agencies who are viewed to be delaying discharge have heard them many times over. The consequences of having escalated an issue were not observed during the field work so conclusions cannot be made on whether the practice helped or made things quicker. Moreover, it appeared to be a way for staff members to pass on the responsibility when they reach barriers that they can't traverse any other way. Once things have been 'escalated' they are talked about as though they are now the responsibility of someone else or sometimes of the organisation as a whole. The frustration of the consultant is evident, and from how the consultant told of the nursing home nurse's response it is likely she was frustrated too. The excerpt also provides an example of the bed seeking behaviour that goes beyond the beds in the hospital as staff look to other places for patients to occupy beds elsewhere such as a community rehabilitation setting or a discharge to assess bed at a nursing

²⁶ Discharge to assess means continuing a persons' social needs in a more appropriate place (such as a nursing home) rather than them occupying a hospital bed for a need determined as purely social. Discharge to assess beds were always located in the community.

home. The preference of the patient does not appear to factor in to the discussion above – the decision has already been made.

Another behaviour used by health professionals that occurs when they have identified a problem or issue in discharge planning is seeking ‘back up’. This was especially evident when health professionals had concerns or worries about the safety of a discharge plan. In the field note excerpt below the AMU nursing team discuss the need to get back up from the intermediate care team in their group interview.

N1: sometimes talking to a patient, the doctors will say they're ready to go home and you've got a little old lady who's sat there very quiet while everything's going on around her and you think somethings not quite right and she'll be talking and you know, she's not happy, she's frightened, she's unsure and she's lacking the confidence, we're watching her transfer and she's gripping whereas beforehand she wasn't furniture walking or nothing but she's gripping you like anything, that's when you need your [intermediate care team] to come in to have a look and to reassess, maybe send them for a little bit of rehab and re-ablement bed, or something just to tide them over to get that little bit more confidence

Nursing Group Interview

Here, nurse 1 describes her assessment of the lady. She describes the patient lacking in confidence to walk and may need a bit more time in hospital. However, despite having made her own assessment, she still feels that it needs to be quantified further by the intermediate care team. She is managing multiple other issues being the senior nurse looking after a number of patients and does not have the capacity to try and make the arrangements that she feels this lady needs. Plus, the quotation indicates that she wouldn't be sure which service is the most appropriate for this patient. It may also be that nurse 1 is unclear about what community options there are. Due to this uncertainty or lack of clarity, back up is sought and the responsibility for the decision for this lady to not go home is deferred to another team.

In the group interview the nurse went on to say about the intermediate care team, **“without them it would be a whole different situation because they will back us a lot of the time”**. This requirement of the community to “back us” is indicative of preparing for inevitable conflict about why the person is not going home. It also implies that without the backup opinion of the intermediate care team, the outcome for the lady who is under confident would be different and that the opinion of the nursing team is not enough of a reason for a discharge to be stopped.

On one occasion, in their group interview the nurses described an occasion where they had had to assert their own judgement to stop a discharge.

Nurse 1; No, I don't care. At the end of the day, and I know it sounds horrible, they can rant and rave at me all they like, this lady in bed 7, I don't give a monkeys who is breaching²⁷, this lady is not ready to go home today

Nursing Group Interview

This quotation provides more insight into the use of language such as “back up” to prepare for conflict. Here, the nurses explicitly describe that if they stop a patient from going home, the response is that “they”, the bed managers or senior managers on the unit will “rant and rave”. Implicit in this quotation however is how self-assured nurse 1 is as she describes this instance. “I don't care” and “I don't give a monkeys who's breaching.” She appears to have had the confidence to advocate for the patient despite the need for the bed. Her assertion that she “doesn't give a monkeys” is indicative of a sense of disengagement with the hospital processes and the leadership and management of the AMU. On this occasion she prioritised the needs of this individual over the need for pace and freeing up space in the organisation.

The intermediate care team discussed this need for “back up” from a different perspective. They reported that the constant need for the AMU nurses to phone them and ask them to review patients was the AMU nurses not wanting to do it themselves. It is therefore likely that ‘Nurse 1’ who “doesn't care” about the “ranting and raving” that may occur if she stops a discharge may not be representative of the norm, especially given her experience. It appears that without “back up” the nurses do not feel that they will be supported in their decisions and assessments that go against the flow of pace on the unit. There was little talk or observation of nurses and doctors discussing their concerns together and coming to a team decision. However, the nurses and the intermediate care team and Physiotherapist did do this.

No specific discharge decision-making conversations or meetings or processes were observed even though these occasions were planned to be the focus of this field work. There was no specific, consistent moment when the discharge decision appeared to be made. In the context of their busyness, the team of professionals on the AMU instead had to categorise patients through a series of factual assertions and qualitative judgements to ascertain whether they were “discharge ready”. If there was an issue in implementing the result of that decision, there was ingrained behaviour of “escalating the problem” which meant that it was now the responsibility of those further up the organisational structures to deal with as the team had got as far as they could with trying to solve a problem. At the centre of discharge

²⁷ Breaching refers to braking the 4 hour ED target as discussed in the previous findings chapter.

decisions was the need for beds and the bed-seeking that could not be uncoupled from discharge decision-making as health professionals were constantly aware of this need as they performed their daily tasks and assessments. All of these behaviours were inherently professional orientated and there was a lack of patient voice or preference often in decision-making processes. No time was allowed for these discussions as professionals fought to balance the demands of their roles in this very busy unit. The approaches of health professionals in comparison to patients will be explored next.

7.1.3 Health professionals have the authoritative voice in discharge decision-making

Throughout the observed interactions and those reflected upon in interviews, the authority for all decision-making and in discussions on discharge on the AMU rested with the health professionals over patients, despite some health professionals feeling the need for “back up” as discussed in the previous section. In particular the language and style of communication often used by health professionals reinforced this fact. They continually expressed their advice and recommendations with an authoritative voice and consequently the patients trusted them implicitly.

The medical team tended to have the most authoritative communication style, not only with patients but also with other members of the multidisciplinary team. The excerpt below from a field note provides an example of that following a conversation between a doctor and the intermediate care nurse.

Before the intermediate care nurse had seen him the doctor had caught us up in the corridor and said “If you think she’s ok, she goes, if not she stays. I’ll do the TTOs [To take out medications], we need to sort her out really because she’s slipped through the net.”

Field Note 22.03.2016

Despite the final decision being that of the nurse in this instance, the communication from the doctor is authoritative. It’s clear. It spells out what task is the responsibility of who. The decision-making on discharge above did not happen in the presence of the patient, this plan was made in a corridor while the nurse walked towards the patient and the doctor walked away. The two professionals happen to come across each other in the corridor and almost pass the baton of discharge planning between them. No mention of patient preference or wishes is made. The doctor’s “slipped through the net” quotation provides insight into the chaos of the unit that has allowed a patient to have fallen off the expected pathway.

The intermediate care nurses often have the authority on whether patients stay or go once they’re medically fit. In the instance below, the nurse was concerned the day before that a patient

was too unsteady to go home as she lived alone. As such she felt a further night in hospital would be sufficient for patient to build her strength a bit more and recover from what brought her into hospital in the first place. The patient is desperate to go home and was desperate to go home yesterday as well. As soon as she sees the nurse approaching her, she begins to tell her how much better she is doing today than yesterday.

The patient says, “I can walk with a Zimmer frame just like at home.” The intermediate care nurse explains why she has come back to visit and what she’d like to assess and see today and asks her a few a questions about how she’s feeling. The patient doesn’t really want to answer these questions and is preoccupied by the idea of going home. “So send me home please”.

The nurse replied, “Well I’m going to see how you do, I need to make sure you can manage.... We’ll walk you now.” The patient responds, “I can go home.”

“Let me get you up on your feet first.” The patient finally obliges and stands up, her hearing isn’t good and so a lot of the nurse’s questions and conversation goes unanswered.

“You’re better than you were yesterday.... Would you say this is how you were at home?”

Field Notes – 22.03.2017

The patient had made it clear that she felt able to go home but the nurse needed things to unfold in the order she was used to – the script of discharge readiness discussions. She visits the patient, asks how they’re feeling in themselves, goes for a walk, ask questions about the support they have at home and then tells them that they can go home, with no adaptability for when the patient answered these questions in the wrong order. In this interaction, the nurse has the authority not only on whether she can go home but also on how and in what order the topic is discussed and the conclusion drawn. The approach is formulaic and reductionist. There is a sense of the health care professional knowing best. The language used is also not in-keeping with empowerment, involvement or shared decision-making. For example, “we’ll walk you now” appears to reinforce that the responsibility and the authority lies with the nurse. Instead, the interaction aligns with more of a paternalistic approach. These kinds of instances are indicative of how the competing demands and pressures require professionals to stick to their script as there is no freedom in their work processes for a different approach.

7.1.4 Patients' take a passive role in discharge decision-making

The patient role in discharge decision-making differed greatly to that of the health professional's role. In contrast to having an authoritative voice, the patient's voice fell on a spectrum between passive voice and no voice at all. During the patient interviews, this experience was unanimous except in one case where Mr Smith chose to take full control of how he got home, but still was passive in determining how fit he was to go home.

When asked about her role in discharge, Mrs South reflected, **"Nothing. Sit there and wait."**

During the interviews, often the concept of patients having a role in discharge didn't appear to register with or mean anything to the patient participants. They found it very difficult to reflect on their role, their job or what they needed to do for discharge to happen. They appeared to have no expectation of a role or responsibility. On the occasions when patient participants were able to reflect on the subject they often talked about the need for themselves and other patients to be patient.

In their interviews, both Mrs Adams and Mrs South had similar advice.

"several times the nurses have said to me "aren't you patient" I said well there's no good being anything else"

Mrs Adams

When asked if she'd give any future patients any advice about discharge, Mrs Kelly reported the following;

"I wouldn't give them any advice except just to listen to the nurses and listen to what they're told"

In the previous chapter, the impact of the environment of the acute medical unit on patients was explored and a picture of patients feeling guilty for being patients was described. Within this, although they didn't explicitly acknowledge the categories of nice versus difficult patients, patients appeared to locate themselves against other patients who were being more difficult. This approach to discharge decision-making as passive, patient patients may be in response to the context of the pace-focussed acute medical unit rather than because of any personal preference.

Similarly, it was also evident in the narratives of patient participants that they were unable, or at least perceived themselves as unable, to influence their own discharge process or decisions. The

code “It’s pointless to argue” occurred in seven different sources within the data, an example of which below is from Mr Orange’s interview.

“there’s no point in arguing the toss, I mean some of the chaps in there I could hear them, moaning and arguing the toss with the nurses, you know, ohh this has happened and that’s happened, it’s no good.”

Mr Orange

Moreover, Mrs Peach provided an example of her having little influence.

“You sort of, you ask questions and they say, “we’ll come back in a minute”

Mrs Peach

Mr Orange appears to be resigned to the fact that “it’s pointless to argue”. Mrs Peach however is willing to ask questions and try to get involved but does not have any sway or influence and instead is told that someone will come back in minute to talk to her. Her experiences is very similar to the aforementioned “wait for the doctor” message discussed earlier in the chapter. Mrs Peach did not describe any instances of discharge being explicitly discussed between herself and health professionals.

The lack of voice and lack of influence rendered patients powerless to sway decisions on discharge. Not only was this built into their experiences, it also appeared inbuilt in their expectations too. It wasn’t something they had to adjust to. They did not talk about coming to hospital with a voice and losing it as discharge plans progressed. It became the status quo as soon as they arrived. There were no instances within the data of patients reporting feeling too unwell to pass opinion, rather they just determined that being patient patient, waiting for the doctor and letting it all happen was their role in discharge decision-making.

Interestingly, in the second phase of the data collection, focussed on the health professionals and in which data collection through observation outweighed that of interview (the opposite to the first phase) more micro behaviours and indications of patients attempting to or exerting some control over discharge were found.

During the observations patients appeared to need to prove to the intermediate care team in particular that they were ready and able to go home. In particular, this field note excerpt discussed previously in the context of health professional’s authoritative voice demonstrates the attempts by a patient to assert her own preferences and opinions.

The nurse heads over to the patient's bed side and the patient obviously recognises her and is quick to start explaining, "I can walk with a Zimmer frame just like at home."

[...]

"You're better than you were yesterday.... Would you say this is how you were at home?"

Field Notes – 22.03.2017

This interaction starts and finishes on the same topic. At the start the patient clearly communicates that she feels she can and should go home, but at the end, the nurse feels the need to ask the question again. The language is indicative of a person trying to influence someone with the power to give her what she wants. "Send me home please" comes across as almost begging. The reciprocal relationship is not there. A "We'll walk you" from the nurse gets the response "I can go home" from the patient. It is then interesting that the patient feels the need to respond by enforcing clearly her own assessment; "I **can** go home". In the end the outcome of the interaction was that the patient went home, but the order in which the conversation went, the structure of the questions, the demonstration and then the decision does not empower this patient who had a very clear idea of what she wanted the decision to be.

Finally, the overall most consistent experience across sources was that older people as patients mainly "did what they were told". Mrs Kelly's son reflected on this during his interview and particularly regarding complex information communicated to her via the consultant.

"I was really glad I was there when she did see the consultant because so much of it just went over her head to be honest, so I don't think she, as to her being involved, I don't think she was, she was just there, doing as she was told basically."

Mrs Kelly's Son

Mr Kelly had determined that his mother's role in discharge and in dealing with the health professionals as very passive and in response to this felt the need to advocate for her and be there for these complex discussions.

This section has detailed the two opposing approaches observed to be taken by health professionals and patients to discharge decision-making. Health professionals are authoritative in their approach, with communication styles often encroaching on paternalistic. They did not deviate from their script even when there were instances of patient's communicating their own

preferences. Patients were unable to identify a role or responsibility in their own discharge decision-making and essentially took a passive stance letting it all happen to them. It is very likely that the pace focus detailed in Chapter 6 allows these two styles to be manifest within the acute medical unit context. Health professionals have to be decisive and they have to be frugal with their use of time to make sure patients get moved along the system. Patients in their role on the unit as 'patient patients' take a passive approach to discharge decision-making.

7.1.5 Summary of the characteristics of discharge decision-making on the acute medical unit

This section has dealt with the third objective in this study to identify the characteristics of discharge decision-making. Discharge decision-making does not occur on the unit in a clearly defined shared decision-making process. The various teams involved in the care of older people on the AMU have different roles but the fundamental responsibility for both deciding and communicating the decision was that of the medical team. Often other professionals deferred having discussions about discharge to the medical team which meant that opportunities for in-depth discussions about what discharge may entail were minimal. Throughout health professionals continually had the authoritative voice over patients choosing both when and how conversations pertaining to discharge took place as well as the outcome. This was true regardless of whether patients were or were not going home that day. As such in order for a discharge decision to be made health professionals had to continually work to categorise and re-categorise patients until they fell into the ultimate category of "discharge ready". Throughout all of this, the need to find beds and free up capacity was considered alongside patients' needs as the atmosphere of the unit became about whether a patient was a good use of an acute bed or not.

7.2 The impact of discharge decision-making practices

This last section of the findings chapters brings together all that has been discussed by meeting the final objective of this study; to understand the impact of the current discharge decision-making practices. The context of the unit and its effect on those within it has already been discussed generically. The first half of this chapter has detailed how discharge decision-making occurs within the AMU context. Here, the impact of current decision-making practices around discharge is explored for patients, health professionals and relatives alike.

7.2.1 Increased expectations and reliance on patient's relatives in discharge planning and follow up support

As health professionals were task-focussed in the pace-focussed AMU context, often, unless relatives actively sought otherwise, assumptions were made regarding what was feasible and available in terms of support from patients' relatives and carers.

For Mrs Peach a friend down the road, John, was often being referred to as her 'carer' which was not an accurate representation of their relationship as she discussed during her interview.

Mrs Peach: they seem to take it that he's my carer and he's not. He comes in when I'm in the hospital he comes through the house checks everything's alright, picks the rubbish up, brings me mail up

I: Is he a friend then?

MP: He's a friend.

And later in the interview;

Mrs Peach; I mean he's come and picked me up and save me waiting up there for transport and I said to him, he was getting in and I said look "he's not my carer, I haven't got a carer cos there's no one left"

[...]

Mrs Peach: And I don't I've got now that I don't want to impose on him

For Mrs Peach, health professionals appeared quick to categorise her friend as a carer (of which having a carer was a green light for discharge – see section 7.1.2.1) but this did not sit comfortably with her. She felt that there was a lack of understanding that meant that the expectations on John to help her were too high and not what she wanted. From John's perspective, being a good friend and neighbour launched him into a position where great responsibility for Mrs Peach was assumed, none of which appeared to be a choice.

Similarly Mrs Adams and her daughter reflected on the impact that Mrs Adams telling health professionals that she had lots of family around her had had on her discharge planning.

Mrs Adams' daughter: Hmm well because when you (Mrs Adams) when you had your stroke, the last time you had your stroke, they did send the rehab team in, but for something like this I think that they did ask, oh actually, I remember that you said to

me that they asked you if you lived on your own and you said, “yes” but the minute you said “but I’ve got plenty of family around” you felt like they shipped you out

This passage implies that Mrs Adams having family around meant that no further questions about extra support or any community input were asked. Because there were family present, the discharge was uncomplicated and she was “shipped out”. As a result, Mrs Adams may have missed out on receiving the extra support that she may have needed. Both patients and relatives reflected on the strain and stress that supporting someone being discharged from hospital can have on those that care for them.

Mrs Peach described John, her friend, receiving a phone call when he was in the shower saying that she was ready to be taken home. He was in such a rush he left both her keys and his keys on his kitchen table which ended up with them both being locked out and an even more stressful situation for him to deal with. Mrs Peach was constantly reminding me that John, a widower in his 80s, has his own medical issues as well.

There were similar issues for younger family members too as was again evident in the interview with Mrs Adams and her daughter.

Mrs Adam’s daughter: but when she has just come out of hospital it takes a lot of our time until we can get her back up and running and she feels confident to stay on her own again

Mrs Adams: yeah

...

Daughter: not this time, but I think partly and I’m sure mum will say, she’s been left on the back burner a bit at the moment because things are quite drastic round the corner (with another family member)

Mrs: No, yeah, he is ... I mean it’s just a case of time now

Daughter: yeah and we’re doing all the caring

Mrs Adams: yeah and I mean they work and they got families you know and uh I keep saying, I said to [son] when he come down, I said “I’ll try to keep a low profile at the moment”

Interview with Mrs Adam’s and her daughter

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In this instance despite acknowledging that when Mrs Adams usually gets discharged she requires some extra support from her family to get set up again, they were unable to do this on this occasion as they were providing more support for someone else. Mrs Adams is therefore “keeping a low profile” but she has no other additional support to compensate because as far as the hospital understood, Mrs Adams daughter was there and able.

Mrs Delahey’s husband had more complex health and social needs than Mrs Delahey as he had Parkinson’s disease and was registered blind. No discussions on whether Mr Delahey was able to support his wife at home were had. He reflected;

Mr Delahey: Well we must have created the illusion that we were capable of coping

Interview with Mrs Delahey and husband

This quotation shows that demonstrates how family support, regardless of context, is determined a “green light” for discharge as it appears that no further investigation or consultation has occurred.

In summary, in the context of pace focussed discharge planning that serves to identify the most simplistic discharge plans that are possible, assumptions are made both about the roles that people play in patients’ lives but also the level of support that they can provide once the person is discharged. This serves to not only increase the burden on those willing (and less willing) to support, but also on the level of guilt felt by the patients as they realise that they are becoming increasingly burdensome- as in Mrs Peach’s case.

7.2.2 Health professionals under pressure to discharge

The ‘moans and groans’ experienced by health professionals resonate throughout the findings and have been described and analysed at length in previous sections of these findings chapters. However, when these frustrations become centred on discharge planning and decision-making they begin to feel more serious. The nurses reported how the pressures that the Trust face filter down to the day to day running of the wards.

N2: I mean, quite often, it’s a chain of information, but, I don’t think there’s a person who works in this Trust that doesn’t know about the pressures this Trust is facing and I

think that on the wards I know that they have got flow managers²⁸. All those people walking round

N1: everybody is now micromanaged with discharges

Group Interview – Nurses

This idea of “micromanaged discharge” was notable across sources. In one field note, I observed a flow manager start a conversation with the nurse in charge by saying “I’m not trying to harass you but...”. The level of stress that this micromanagement induced for the AMU nurses became clearer as the group interview progressed. The nurses continued to reflect on this pressure from management.

N1: but sometimes the management ... are just not grasping the fact that ... I’m nagging the arse off my doctor and my doctor is not doing the TTOs or Pharmacy is hammered where they’re getting like 20, 30 discharges, they’ve still got to do the tablets safely, they’ve still got to assess, they’ve still got to do it, it’s not like, you’re going there’s your tablets. ... they don’t understand the fact that ... you still have to cross certain things to be able to get to the end and sometimes it’s like “well why haven’t they gone?” and it’s like “the TTOs aren’t ready, they’ve not been screened or waiting on transport” and “can’t they go in there?” “This lady is climbing out the edge of the bed, I’m not putting her in discharge lounge”. There are some patients that can’t go to discharge lounge, you just can’t, if a patients exceptionally disorientated I’m not going to move them again.”

...

N1: and by them all coming out of their offices, standing and looking at us, it isn’t going to make it happen

I: who’s that? Flow managers?

N1: yes

Group Interview - Nursing

The pressure and how frantic it made the nurses feel is evident in the extract from the nurse’s interviews. They are not being pressured to involve patients in their discharges, to make sure they communicate the preferences or to make sure the team aren’t assuming the support their

²⁸ The main role of the flow managers is to ensure the trust meets targets and try to prevent any bottlenecks or delay in the flow of movement of patients through the expected routes (i.e. ED - admission to AMU - specialist ward - home).

neighbour can provide. Instead they are being continually pressured to free-up space and expedite aspects of the organisation of patient's discharge (regardless of whether the patient knows about it or not). The patients do not get to choose whether they go to the discharge lounge. It depends on the bed managers and whether the nurses have enough evidence to argue otherwise.

This experience was not only experienced by the ward nurses, but also by the intermediate care nurses too. Below is an excerpt from a field note following a discussion with one of the intermediate care team followed by an excerpt from the junior doctor's group interview.

We talk briefly about hospital managers and bed managers. The intermediate care nurse tells me that she feels like sometimes in times of pressure their constant pressuring is akin to "passive bullying". She says she's had times when they've confronted her and said "you haven't got to [AMU] yet, so I'm going to put them in the discharge lounge".

Field Note 22.03.2017

D3: I think as I say the pressures I've experienced, that when someone's medically ready and then you're getting everything ready and then the family come and suddenly bring up a whole load of things that you can't have necessarily predicted but then it's really tricky because it's already been signposted that that persons going and they've practically already putting someone else into the bed and then the family are like "they're not safe at home they're not good to go" and then that's quite difficult

Group Interview Junior doctors

From the perception of "passive bullying" to constant pressures, the health professionals on the AMU feel that the concern from above, from "them" and from the bed or flow managers is focussed on getting people out, rather than on the patients themselves. Firstly, this focus leads health professionals towards a behaviour of searching for "simple discharges" where no problems, complications or delays arise. This was evident by the self-congratulation that I saw following one of the intermediate care nurses' assessments on a patient that appeared simple to discharge.

"Do you need a prescription for paracetamol?" "No, no, I have that at home" says the patient. "Right then, well you don't need to wait for any medications then!" says the intermediate care nurse. She is obviously happy having identified that there will be no need for take home medications to be organised. The patient asks "can I phone my

sister to come and collect me now?” “I don’t see why not”, says the nurse. “Great, thanks” calls the patient after the nurse as she marches back to the nursing station. She then feeds all this back to the nurse in charge who confirms “great and she doesn’t need transport!” “Nope!” says the intermediate care nurse, almost triumphantly.

Field Notes 15.03.2016

When the discharges are simple, everybody is happy and appeared to get great job satisfaction, despite having had to do very little towards making the discharge work. The physiotherapists demonstrated a similar experience;

The Physiotherapist says triumphantly, “(The other Physiotherapist) and I have seen 19 patients today - that’s a record!”

Field Notes 15.03.2016

In this excerpt from field notes on the same day, the physiotherapists congratulate themselves for seeing a record number of patients in one day. The quality, speed or purpose of their interventions in this time are not discussed, just the number of people they’ve seen.

It is clear from these health professional experiences that they are rewarded or they feel triumphant when their work aligns with the pace focus of the unit, even if the quality of their care may have waived or the outcome didn’t need much work from them. When their work is not pace focussed, when they have had to stop a discharge due to new information or decided that someone can’t manage at home – they experience what they describe as “passive bullying” and “pressure” like the aforementioned experiences, despite the likelihood being that these are the right and patient-centred outcomes for these patients.

7.2.3 Patients – on the conveyor belt

The language used by patients in describing their discharge on the AMU was not always conducive to the personalised, person-centred, caring, dignified, involved care that policy and professional recommendations call for as discussed earlier in chapter 2 and 3.

Participants provided two powerful images to portray the AMU discharge experience.

Mrs Adams’ daughter described the Acute Medical Unit as follows; **“It’s like a holding bay ‘til they decide”**. Firmly setting the authority and power with the health professionals. Similarly, Mrs South reflected, **“You just felt part of a conveyor belt”**, a statement that is comparable to some

of the interactions previously discussed where health professionals have been task-focussed and prescriptive.

The 'holding bay' and 'conveyor belt' imagery are similar. Neither represent a human experience, both are indicative of inanimate objects lined up waiting and both are associated with a process driven system. Mrs South was able to elaborate on her choice of 'conveyor belt' as a comparison.

"I don't recall any decent conversation, I felt like I was wheeled in, sat there, blood pressure, put on a drip, cos I was low on fluids, that came out, it was in my hand, that came out, uhm and more or less it, I felt ignored to be honest."

Mrs South

Mrs South had complex needs, she was reliant on being fed via a percutaneous endoscopic gastrostomy (PEG) tube. During her visit to the AMU her PEG feed was forgotten. In addition, the staff appeared to handover to each other that she was to remain 'nil by mouth' as a result of her PEG feeding, which meant she didn't eat for over 12 hours. Mrs South had a particularly bad experience of being on the AMU, but even in the accounts of those who were complimentary of the care they received, those who expressed awe at the speed and efficiency of the nursing team as discussed previously, similar sentiments on the theme of the 'conveyor belt' were evident. The feeling of being ignored and having no influence on the care being received transcended all of the patient participants' experiences.

Mr Gilo referred to being discharged as **"they slung me out"** and **"the professor man got rid of me"**. Mrs Adams talked of being **"bundled up and down to the discharge lounge"** and feeling as though **"they're going to tip me off the wheelchair and say, "right, there you are"."** Mrs Andrews' daughter explained how her mother was **"shunted into another area"**. Mrs Delahey told how **"it was Friday afternoon and they were trying to get rid of everybody"**. Mrs Norway reported the day before she was discharged, **"I think they're trying to get rid of me"**. Even the nurses in their group interview talked of patients **"being kicked out, when no one's even sorted their issue and they don't understand something that is being looked at" (N1)**. Finally Mrs Adams reported **"I felt as though I was being shoved out this time, and that's unusual and I wasn't being shoved out but that's how it felt"**.

Mrs Adam's quote is particularly interesting because she acknowledges that she wasn't being "shoved out", yet still felt as though she was. The continual use of verbs such as "shoved", "kicked", "shunted", "bundled" "slung" and "got rid of" are all indicative of rush, carelessness or even forcefulness. They all have a sense of urgency and of quick reaction. They create a picture of pace fitting with the findings discussed previously.

7.2.4 Summary of the impact of how discharge decisions are made on those involved

The final section of these findings chapters has dealt with the fourth objective in the study; understanding the impact of current decision-making practices on health professionals, relatives and most of all, patients. The way discharge decisions were made on the AMU, with little involvement from patients and a prescriptive approach from authoritative health professionals continually categorising patients to assist with their movement through the system, evoked largely negative experiences for those within it. For relatives, as communication and information gathering is poor, assumptions are made on what they can do to support discharge which places undue strain on often already stretched relative carers. For health professionals, the pressure continues to increase as they sense a “passive bullying” from the organisation around discharge decision-making that reinforces their need to prioritise pace. Both this, and the findings indicated in the second half of chapter 6, leads to very demoralised staff who are ingrained in a culture where they are rewarded only when they have successfully prioritised pace and assisted in creating capacity and not for when they have provided holistic care that has meant stopping or delaying a discharge. For patients, who should according to policy be consistently involved in their discharge decision-making, their continual effacement of their own needs and wishes means that they are left with a dehumanising experience of being pushed around from place to place on a conveyor belt with no influence on their discharge decision-making process.

The following quotation from Mrs Andrews aptly summarises the findings presented in this thesis. Within the acknowledgement of pace, busyness, health professionals having authority and her having no role at all Mrs Andrews says;

“they probably didn’t realise how I really felt because I, I wasn’t chatting [to] them, they’re so busy, I wouldn’t have chatted [to] them about myself.”

Mrs Andrews

Chapter 8: Discussion

8.1 Introduction

The aim of this study was to explore and understand the processes by which discharge decisions are made for older people returning to the community from an AMU. The findings met the following objectives;

1. To understand the context within which discharge decisions are made
2. Explore the impact of the context of the AMU on those involved in discharge decision-making (patients, staff and relatives).
3. Explore the impact of the AMU context on discharge decision-making and identify the characteristics of the process of discharge decision-making in this context
4. Describe the impact of discharge decision-making practices on all those involved in the process (patients, staff and relatives).

The opening chapters of this thesis introduced concepts such as independence and autonomy and provided a background of the issues and current theories behind how older people experience acute care and how it can be improved. Some of these key texts will be re-visited in this chapter to help situate the findings of this study in its empirical and theoretical context. Chapter three provided the policy context of involvement and shared decision-making for comparison with the realities of discharge decision-making that have been explored in this study. In chapter three, shared decision-making was defined as an ideal approach to discharge decisions that acknowledges the relational context within which people make decisions. The policy messages from UK government and UK professional bodies introduced in chapter three have continually supported patient and public involvement and shared decision-making. However, in recent years, there appeared to be a re-focus away from patient involvement and shared decision-making in the context of increased demand, a “modest spending increase” and a need to focus on patient flow to free capacity in 2000-3000 hospital beds in the English NHS (N.H.S. England 2017 p.15).

Chapter four provided a critical overview of the current literature with regard to discharge planning and provided a focussed qualitative synthesis on patient experience of discharge decision-making. The discharge planning literature was varied and studies with a naturalistic element were deemed the most insightful and helpful to this doctoral work as many studies highlighted cultural, organisational and system issues in discharge planning processes. Chapter four concluded that existing research findings indicate a growing gap between best practice recommendations of patient involvement and shared decision-making and patient experiences of

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a lack of involvement in discharge planning. The findings of the qualitative synthesis demonstrated that patient's participation in decision-making may be limited by their embodied trust in health professionals as discharge decision-makers. The full context surrounding discharge decision-making, particularly in a short stay context had not been studied. These studies will be drawn on as the findings of the current study are discussed later in this chapter.

Chapter five detailed the methodological approach and methods undertaken to complete the study. An ethnographic approach was used, in-keeping with the approaches identified in the literature review as effective and appropriate methodology for the aims and objectives of this study. This enabled a detailed exploration of the phenomenon of discharge decision-making within its cultural context. The two phases of the study were described and the personal positionality of the researcher was provided to enable readers to interpret the findings of this study with explicit detail and insight into the researcher's influence in the field, field relationships as well as the lens within which interpretation and analysis took place. Chapters six and seven then described the findings of the study structured around each objective.

This chapter discusses the key findings of this study; the lack of space temporally, geographically and organisationally as well as the impact of the fixed temporal rigidity of the unit and how it services to reproduce itself.

During the analysis of this work and acknowledging the omnipresence of 'pace' throughout the findings Zerubavel's (1981) sociotemporal perspective on the rhythms of organisations is used to pull together the findings of this study within the theoretical and empirical grounding detailed in chapters one to four. This discussion illustrates how this work adds to and has generated theoretical understanding of discharge decision-making and the pace-focussed environment of the AMU. The potential limitations of this study are described and recommendations for further work and practice provided. Finally, the discussion is summarised and a list of recommendations for further work and thinking is provided.

This study makes a unique contribution to knowledge about how care for older people is enacted within the current cultures of acute clinical environments in the English NHS. In focussing on a specific practice problem in a specific AMU and by identifying friction between policy and practice, this study has drawn out how patients, context and health professionals interrelate in discharge decision-making; the way patients present themselves, how health professionals behave in discharge decision making and the temporal rigidity of the AMU that does not allow any flexibility for the unpredictable and uncertain needs of older people. This pattern is likely generalisable to other clinical units in the English NHS that are fundamentally driven by a

utilitarian-economic, quantitative perspective of time, which as capitalism and consumerism grow in UK healthcare policy will be a large proportion of NHS services.

Some of the themes explored in this discussion chapter also require consideration and debate by NHS users and the wider public regarding aging and the provision of quality NHS care within the current “time is money” iteration of the English NHS (Zerubavel 1981; Russell & Greenhalgh 2012).

8.2 AMU focussed on the needs of the organisation. A lack of space for shared decision-making

The first objective of this study was to understand the context of the AMU where discharge decisions are made. In this study the AMU was found to be busy, chaotic and constantly in flux. There was a constant push for pace focus in the way that the unit was organised. Despite this there were also constant barriers to efficiency in the form of disjointed and repetitive processes and an environment that was also not fit for the swift throughput of patients. There was a constant disparity between the pace agenda, of which the expectations were made very clear from the outset to patients, relatives and visitors to the unit, and the inefficient systems in place. The study also identified some service gaps as well, for example in the provision of equipment, which is deemed a routine need in AMU environments. The key driver of this pace focus was the government set four hour ED target that penalised the Trust with financial penalties if not met. As such, the meeting of this target was the priority. This filtered down to a constant agenda of pace in all of the health professional’s practice and the patient experiences.

These findings reflected the findings of both Williams et al. (2009) and Patterson et al. (2011). The focus on the ED four hour target over some aspects of patient care reflected what Patterson termed as “metrics over meaning” where success is attributed to meeting punitive targets rather than in an area of quality or experience. One of Patterson’s quotes from a consultant in their study, “*the urgent is the enemy of the important*” has many parallels with the experiences of health professionals in this study. Williams et al.’s (2009) theory on the pace-complexity dynamic was also evident throughout the data, consistent across sources, methods and time. As was theorised, pace was the focus in the AMU over complexity. Therefore instead of advocating for patients and involving them, behaviours of pushing people out and a sole focus on medical problems were present throughout (Williams et al. 2009).

Another of this study’s objectives identified the characteristics of the process of discharge decision-making and explained the impact of the context of the AMU on the practice of discharge

decision-making. The findings of this study concluded that in the AMU context various behaviours were enacted to assist in the discharge of patients such as categorising, escalating and bed seeking. Health professionals had the authoritative voice, not only in the outcome of discharge decisions and even with regard to the rhythm and order of conversations. Health professionals often stuck to a script that sought to get the information they needed in the quickest time possible. As such, patients were passive in their discharge decision-making often describing having no role and no conversation separate to a “you can go home now” instruction from a consultant.

8.2.1 The temporal rigidity of the pace-focussed AMU

Discharge decision-making involved categorising patients using dichotomies. Within the pace focus, these categories had to be simplified. Subjective qualities and assertions that in reality more represent a continuum were reduced to black and white or yes and no²⁹. The categorisation of patients to induce movement through a healthcare system is well known (Latimer 1999) but the findings of this study have provided a context for the overreliance of categorisation in contexts when pace is a priority. When pace is the focus there is no space for shared decision-making. But also, incorporating the work of Williams et al. (2009), when pace was the focus on the AMU there was no space for understanding the complexity of a person or patient. As such, their needs, preferences, wishes, circumstances and behaviours were dichotomised and oversimplified. Inevitably, this overreliance on over simplified categories, ensures a decision-making process that oversimplifies the individuals within it. Therefore discharge decision-making did not represent person-centred care.

Fundamentally the AMU is an exemplar of a clinical environment governed by the need to meet financial and service targets, the four hour ED target, the increasing need to reduce the use of beds and the number of days spent in them. This tension is symptomatic of a broader idealistic change in healthcare and particularly the NHS of rationalisation and affordability within a utilitarian context whereby NHS organisations consider the needs of the population over the individual (Russell & Greenhalgh 2012). Through a temporal lens, the numerical or quantitative focus of the AMU³⁰, is indicative of an NHS organised within an economic-utilitarian philosophy of time where time is countable and measurable and time is money (Zerubavel 1981).

²⁹ For example; medically fit for discharge, safe, at baseline, well supported.

³⁰ Reinforced by the expected length of stay of 24-48 hours, the intermediate care team’s KPIs around seeing people within a certain time frame of hours and then justifying when this hasn’t been achieved and the overarching focus on preventing the ED from ‘breaching’ its target of assessing all patients within four hours.

A quantitative conception of time also brings homogeneity in the way time is spent (Zerubavel 1981). Particularly within hospitals, and evident throughout the findings of this study, the AMU is “clockwork³¹” with a bureaucratic sequential rigidity that favours predictability (Zerubavel 1981). This study has found that the oversimplification and binary categorisation of patients through the discharge process on the AMU responds to and maintains this rhythm of the AMU.

Ideally in social environments with temporal sequential rigidity this rhythm is maintained by a temporal symmetry where the activities of individuals are in-sync and a sense of togetherness is felt (Zerubavel 1981). However, rigidity does not allow for improvisation or any deviance from this rhythm and reinforces an intolerance for what Zerubavel (1981) terms ‘temporal anomalies’ where there has been an unexpected occurrence of an event or person outside of their usual or expected ‘temporal niche’. Temporal anomalies evoke a chaotic incongruence within what is expected by those in the social environment (Zerubavel 1981). The chaos felt on this unit, particularly surrounding the discharges of older patients and unwelcome delays demonstrate these temporal anomalies. These were frequent, so that chaos was one of the overriding feelings on the unit but still the temporal structure continued to be fixed.

These such incongruences featured significantly in the findings of this study, particularly within the experiences of health professionals. The junior doctors described one occasion of a patient’s discharge being arranged and ready to go, only for the relative of that patient to bring forward information, worries and issues at the last minute that made it untenable that this patient go home as was planned. In this instance, the rhythm of the unit swept towards the discharge of the individual. To maintain that rhythm the patient was continually categorised towards being ‘discharge’ ready and the full complexity of their needs not captured. Another example in junior doctors’ accounts was the case where a patient had had their whole discharge planned and organised before they had been deemed medically fit. On this instance, their discharge had to be stopped as they were still acutely unwell and unable to go home due to outstanding medical need. Here, the rhythm of the unit towards discharge planning continued without full consideration of the holistic need of the patient.

The chaos of the unit and the pace focus was consistently represented across the findings in this study. This study has provided new theoretical understanding, using Zerubavel (1981)’s lens of sociotemporal patterns, that the temporally rigid and bureaucratically driven rhythm of the unit does not allow any temporal flexibility to understand the complex needs of older people being

³¹ See the Field Note vignette in section 6.3.1 that shows the predictability of the unit and the ability to tell the time by the routines that presuppose the temporally rigid structure of everyday life on the AMU. It’s possible to know that it is morning on the unit when the behaviours and senses detailed in that vignette commence.

discharged from an AMU. The sense of chaos on the unit is a product of the unit continually responding to and reproducing this rhythm and pace focus by oversimplifying individual need and being unable to accommodate scenarios where the individual need does not fit the rhythm.

8.2.2 Discharge decision-making process in a temporally rigid, pace-focussed AMU

As referred to above, in this pace-focussed context, the pushing out of patients over any involvement or advocating was the overarching approach that appeared entrenched in the norms of the unit (Williams et al. 2009). The normalcy of this was maintained by a bureaucratically driven, rigid temporal regularity (Zerubavel 1981). This study concludes that when the norms of a unit bolster this rigid temporal structure towards pace, there is a lack of space temporally, organisationally and geographically for patient centred care, such as shared decision-making, to occur. The AMU was organised and commissioned to meet the needs of flow, patient movement and pace within a quantitative approach to time. As a result of this, in response to the rhythm of the unit, decisions were made in a way that catered to this pace and capacity objective despite the continual policy recommendations for person-centred approaches including shared decision-making.

To summarise discussions in Chapter three, shared decision-making has been an overarching recommendation for all health and care decisions for all populations by research, NICE guidelines and policy think-tanks (Godolphin 2009; Coulter & Collins 2011; N.I.C.E. 2016; Joseph-Williams et al. 2017). Shared decision-making has continually and consistently been recommended with regards to discharge and acute care in research and best practice guidelines (Bridges et al. 2010; The British Geriatrics Society 2012). The Kings Fund identified the three components that need to be adopted to ensure shared decision-making can occur; evidence-based information on options, uncertainties and potential outcomes of difference choices; decision support counselling to ensure clarity of options and preferences and a system for recording the decision, the associated preferences as well as implementing them (Coulter & Collins 2011). None of these factors were evident in discharge decision-making on the AMU in this study. Occasionally patients' and relatives' preferences were voiced but these were not discussed by AMU staff, limited information was provided to patients and relatives and patient preferences or wishes were often not acknowledged while the temporally rigid rhythm of the unit was maintained. Other studies confirm this lack of shared decision-making in other acute medical settings internationally (Ekdahl et al. 2012; Dyrstad et al. 2015). Interrelating this with the utilitarian-economically driven temporal rigidity that frames a pace focus of the unit's culture is novel to this study.

In concluding that shared decision-making did not take place on the unit, the next step is to define how decisions were made. Applying the findings above to Arnstein's model (Figure 1 in section 3.2) of participation, the level of participation would not move beyond the rungs of 'tokenistic participation'. Quite often, only 'informing' was seen in the field. Field notes described health professionals informing patients of the outcome of their assessment without further discussion. Occasionally 'consultation' and 'placation' took place, particularly when patients were asked their preferences on going home, although these preferences were often overlooked³². 'Partnership' was never observed in the findings. Table 10 applies Tritter's (2009) model of involvement to the current experiences of older people's involvement in their own discharge decision-making.

Table 10 Applying Tritter's model of involvement to the findings

	Direct		Indirect	
Individual	Proactive	Reactive	Proactive	Reactive
Collective	Proactive	Reactive	Proactive	Reactive

Discharge decisions for older people in this study were indirect because they only entailed a level of informing on the outcome of the decision. Patients are superficially asked for their preference but the final say on discharge readiness is made by the health professionals (with potential for decisions to be overridden by the organisation). The decision is reactive as patients are unable to influence the path the decision-making process takes, it is already a pre-defined process of categorisation which the patient has little influence over and moreover isn't often aware of. Arguably it is an 'individual' decision as it affects particularly one person's life; the patient. However, in consideration of the inter-dependency of humans as actors and with consideration of relational approaches to autonomy acknowledged in chapter two, it is likely that it is truly a 'collective' decision between health professional, patient, family and any other person who may hold influence over the patient. In this study's context of a 'reactive' decision without patient influence, the 'collective' body that influenced the decision was the organisation and the health professionals working within it. In applying Tritter's model, this study has been able to describe some of the components of the discharge decision-making process in the AMU. Tritter's model however cannot assist in understanding what must change in order for shared decision-making to take place nor the impact of the current practice on experiences and outcomes.

³² An example in the field notes would be the patient who continually affirmed her statement that she wanted to go home, but the nurse didn't acknowledge this preference until the conclusion of going home fitted with her own assessment and perspective. The nurse is acting within the pace focussed rhythm of the unit.

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In mapping the key components and organisational influences on discharge decision-making (Figure 14) it is possible to identify the contributing factors to the lack of space for shared discharge decision-making on the unit as well as some of the impacts of this. Some of the themes regarding the pace-focussed context of the AMU are listed down the left side of figure 14. On the right side, some behaviours and feelings that emerged in the findings are evident for patients, relatives and health professionals. The arrows indicate when it was observed in the data that one factor appears to have contributed to another. For example, the pace focus contributed to patients feeling as though they took up time. The environment not being fit for purpose (more explicitly, the sense of a lack of physical space) contributed to the patients feeling like they took up space. These two factors alongside the feeling of using resources contributed to patients feeling self-aware and then starting to question their legitimacy or the legitimacy of their claim on space, time and resources. Another example, using this map, is the pace focus contributing to some of health professionals' decisions or clinical judgements being overridden (particularly with regards to bed moves – as the findings made clear). This, coupled with constant and short-lived organisational change (as the intermediate care team in particular experienced), contributes to the sense that health professionals feel powerless to influence their work and their organisation. This then contributes to health professional's general dissatisfaction in working on the AMU. It is clear from this map that the primary influence is the inherent pace focus of the unit.

This pace-focus provides the temporal anchoring for which the social world on the AMU is temporally situated (Zerubavel 1981). Disjointed processes and the environment not being fit for purpose also contribute but to a lesser extent. Arguably some of the disjointed processes could be accounted for as symptomatic of the temporal rigidity and lack of flexibility of the bureaucratic pace-focus. This map is not exhaustive of the findings, but provides some explanation and background to why decisions are undertaken as they are due to the lack of space geographically, organisationally and temporally for a different approach such as shared decision-making to occur.



Figure 14 A lack of space for shared decision-making and the impact on experience

It is likely that it is not just discharge decision-making that is affected by the temporal rigidity and associated normalcy of pace-focus of the AMU. Other studies have drawn attention to the gulf between recommended best practice and feasible change in current NHS cultures and clinical environments. Other authors have noted that person-centred initiatives, of which shared

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decision-making is one, are deprioritised in the current organisation and structure of acute hospital healthcare (Williams et al. 2009; Patterson et al. 2011). NHS services are designed with pace and capacity as a main priority (Patterson et al. 2011). As discussed previously, this focus is symptomatic of the utilitarian focus of rationalising services and the utilitarian-economic philosophy on time, where time equates to money (Zerubavel 1981; Russell & Greenhalgh 2012). Staff behaviours seen in this study such as bed seeking, oversimplified categorising and chasing and escalating are all resultant of the rhythm of the system. This study is novel in concluding that the temporal inflexibility of the culture on the AMU means that there is no conceptual space for shared decision-making to be attempted, let alone achieved. This tension results in a discharge decision-making process that does not resemble the pictures of autonomous patients in control of their own health and care that policy depicts. Shared decision-making even as a concept to be aiming for, is not part of the norms of the AMU.

Although it has been acknowledged that acute care is a very difficult environment for shared decision-making practices to be established, likely associated with the inherent pace focus evident in this study, it is still continually recommended. Cribb (2011) is concerned that the continual pushing of agendas like shared decision-making without adequate consideration of the practical implications has only served to further prevent its effective adoption in practice more. The first issue to address is how to create the temporal space and flexibility that is needed so that the system is able to anticipate and cope with the complexity involved in caring for and discharging older people. Until this is achieved, fine-tuning the approaches used is likely to continue to be unsuccessful, and Cribb (2011) is right to suggest that policy reaffirming an approach that the system fundamentally does not allow would only serve to frustrate those within it further.

Evidence continues to suggest that shared decision-making could aid in meeting the aim of pace, of appropriate use of beds and of the prevention of readmissions particularly for older people with frailty (N.H.S. Institute for Innovation and Improvement 2011; N.H.S. Improvement 2017). However, this study theorises that these same quantitative goals help to bolster the current pace-focussed rhythm that enables a push to meet the four hour ED target and free up capacity. This study has concluded that where a bureaucratic temporal rigidity is embedded in the organisation, there is no temporal flexibility. No flexibility to incorporate the complex needs of older people, but also no space for shared decision-making and other patient-centred initiatives that require flexibility to be achieved. An overhaul in approach is therefore required to re-draw the 'temporal maps' of the unit so that complexity is expected and the system can adapt temporally to accommodate it. This will require consistent commitment at all levels; local policy, governance, leadership, management as well as the physical provision of space for things such as discharge decision-making discussions in clinical units. For this to be achieved, we need to acknowledge and

debate the effect of the current economic philosophy of time that is reinforced and consistent throughout the policy rhetoric in healthcare. A recent BMJ article prompted debate of the four hour ED target particularly as Campbell highlighted the lack of evidence for why four hours was deemed the 'proper' time and highlighting once more that target driven behaviour was one of contributing factors to the scandal of failings in Mid-Staffordshire (Campbell et al. 2017).

In conclusion, this study has found that the current bureaucratic, rigid, temporal structure of the AMU lacks flexibility for those whose needs do not fit, an exemplar of which are older people. Instead of shared decision-making, as consistently recommended, patients experience a reactive, indirect and collective approach to their discharge decision-making that they do not contribute to. Such a rigid sociotemporal rhythm appears unable to easily incorporate any patient-centred initiatives, such as shared discharge decision-making as long as the organisational motives and policy stay committed to utilitarian-economic commitments such as reducing bed numbers, length of stay and four hour ED targets.

8.2.3 The impact of a discharge from the AMU on the patients - Self-effacing and powerless

The overall experience for patients being discharged from the AMU was a sense of being pushed, shoved, bundled up and got rid of despite superficial compliments and positive comments about the care they received. The findings of this study demonstrated patients attempting to position themselves as patient patients within the chaotic pace focussed environment that they were witness to and a part of. Latimer (1999) termed this phenomenon as patients 'actively self-effacing themselves' in a bid to preserve their identity even if in a diminished way. In the context of the aforementioned rigid temporal regulation of the unit, they actively sought to minimise their own needs to fit the rhythm that they witnessed. The voicelessness of patients in discharge decision-making has been discussed previously (Huby et al. 2004; Ekdahl et al. 2012). As a feature of their effacement, patients in this study chose not to discuss their concerns or worries with health professionals as they positioned themselves against other patients and worried about their legitimacy as patients occupying beds in the hospital within the background of a very public under pressure NHS system.

Experiences of patients on a conveyor belt and being shoved out were also found in previous studies. Connolly et al. (2009) described this phenomenon as patients being oversimplified and systemised in a pace focussed organisation (Williams et al. 2009; Maben et al. 2012). This study has concluded that this experience is still present in AMU and short stay environments, despite the issue being highlighted five years before data collection commenced, little has changed. The

findings in this study also provided further examples of Maben et. al's (2012) "poppets". On the AMU, "poppets" were discussed in often patronising language amongst professionals and received little extras in their care³³. This study adds to Maben's poppets and parcels theory by demonstrating that when pace is the focus within a bureaucratically driven rigid temporal structure, only a select few patients are given the "little extras" in their care and these are likely patients whose care fits within the temporal expectations of those working on the unit.

In addition, the findings of this study adds further insight in identifying that there are often potentially ageist or patronising undertones in the care provided within this "poppets" category. Further work is therefore required to delineate person-centred care from care that may feel to those providing it like "little extras" but that does not serve to acknowledge the personhood, preferences and wishes of older people. This potential infringement on dignity appears to be expected within the current organisation of acute care for older people. In an in-depth exploration of the experience of dignity in acute hospital wards it was found that dignified care, as well as person-centred care as previously discussed, was at risk for older patients in the hospital environment due to the confusing environment and the practice pre-occupation with process, tasks and targets (Calnan et al. 2013).

Maben et al's final category was that of "problem patients" who were demanding of staff time. No examples of "problem patients" were captured in this study but still the phenomenon of "problem patients" was present in the narratives of patients. Patients felt they witnessed "problem patients" during their time in the AMU but "problem patients" were not identified in the narratives of health professionals nor in the field notes. This shows how aware older people were of the risk of being a "problem patient" and their determination to distance themselves from that. This was at the centre of their consciousness; avoiding being seen or categorised as this negative, polluted category (Latimer 1997; Maben et al. 2012).

8.2.4 The legitimacy worry for older patients in the Acute Medical Unit

Building on Maben's model of poppets and parcels, this study also identified a further category of the 'illegitimate patient'. Legitimacy featured within the work of Latimer (1999) in discussing the category of legitimate medically unwell patient as well as the lack of authority of patients to author their legitimacy or the legitimacy of their needs in the acute hospital environment.

Patients presenting with legitimate medical need has been a fixation in the NHS to the detriment of the care received by older people as they risk being assigned to categories such as 'acopia' and

³³ A specific fieldnote example would be the man who received a woolly hat by the health care assistant who had felt he must be cold.

'social admission' (Oliver 2008). As discussed in chapter two, if a patient is consigned to a negative category, such as illegitimate patient, there is a risk that the self and identity of that individual is diminished (Cohen 1994; Pickard 2016).

More recently than Latimer's work, Hillman (2014) discussed how patients and relatives in the ED are implicated in staff's production of their illness behaviour as either deviant or legitimate as attendees. Patients' and relatives' accounts of their illness are produced in the knowledge that they will be scrutinised for their moral content by members of staff (Hillman 2014). Hillman completed an ethnographic study over four years which involved the tracking of 50 older patients through their ED assessment. Similarly to the findings of this study in the AMU, older people routinely cited that they did not want to take up space in the ED as they perceived their "claim to the services ... as being less legitimate than claims made by others" (Hillman 2014 p.8). In the AMU, the claims to services is less about getting in to the service, as in the case of Hillman's ED research, but more about justifying their continued stay there. Being unwell is morally ambiguous and unwell people, particularly older people, are vulnerable to being categorised in deviant or polluting categories (Cohen 1994; Latimer 1997; Hillman 2014). As such, there is a moral component to how a person, in this case a patient, portrays themselves in any given social situation, in this case in hospital and more specifically in the discharge decision-making process.

When an individual projects a definition of the situation and thereby makes an implicit or explicit claim to be a person of a particular kind, he automatically exerts a moral demand upon the others, obliging them to value and treat him in the manner that persons of his kind have a right to expect.

(Goffman 1959 p.22)

The key aspect of Goffman's interpretation of situational identity is that how an actor chooses to represent themselves reflects their definition of the situation. This is built on by Cohen (1994 p.94) who argues that in organisations, 'Management' may "propagate a symbol" that conveys intended shared meaning which is then interpreted and manipulated by actors within the organisation who mould their identity to fit in a way that protects a self-interest. In this study, it has not been concluded that it is necessarily the intension of hospital 'management' that patients are self-effacing, but that the policy and drivers nationally and locally surrounding AMU organisation serve to propagate the rigid temporal structure and pace focussed rhythm of the unit which is highly visible to patients. There are constant cues for patients in the AMU of the pace focus that serve to reinforce the definition of the social situation; such as the leaflets, the bed status flip-chart, the apparent busyness of the health professionals and the fact that things are so urgent on the unit that even night time, which is usually viewed in society as private is full of

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movement (Goffman 1959; Zerubavel 1981). As older people are consciously aware of the risks to their identity of being consigned to a polluting category, they observe the rhythm of the unit and present themselves in a way that places a moral demand on the other actors in the AMU so that they receive the kind of care they expect and have an identity acceptable to them upheld. Older patients tell health professionals that they want to go home, they never wanted to come in the first place and behave where possible like patient patients. As such they achieve a 'fit' with the rhythm of the unit and are liked by the professionals around them accepting the risk of potentially minimising their own needs, concerns and preferences.

In addition, the patient narratives in this study highlight how the short length of stay appears to contribute to legitimacy concerns further. In this study it was during their interviews at home when patients most frequently told of their intentions never to have presented to the hospital or to go home as soon as possible so as not to take up space on the unit. The post-discharge reflections on their stay and the shortness of it appeared to contribute to their concern that their presentation to the AMU may not have been "legitimate". By considering the sociotemporal rhythm of the AMU, further risks to the legitimacy of being a patient have been identified in this study. The bureaucratically led rigid temporal structure of the AMU brings with it fixed conceptual ideas of time and duration, particularly with regard to length of stay (Zerubavel 1981). Elsewhere in the hospital length of stay is "rounded off" to days or nights, however in the AMU, initiated by the ED, length of stay is "rounded off" to hours (Zerubavel 1981). Not only does this highlight the pace focussed rhythm of the unit, but it also reinforces well defined ideas of 'proper' durations that imply deviant character to improper durations, the most relevant for older people on the AMU being the deviant behaviour of overstaying these fixed durations (Zerubavel 1981). Alongside fixed ideas of duration, are fixed ideas of tempo – in this instance fast-pace that also serve to make deviant those for which care may not be undertaken within this 'proper tempo' (Zerubavel 1981).

This study confirms some of the potential deviant or polluting categories for older people to avoid in the AMU by maintaining their identities as good, patient patients in order to fit within the rigid temporal structure; those whose needs are social (Latimer 1999; Oliver 2008), those who don't require specialist acute medicine (Latimer 1999; Hillman 2014), socially dependent older person who have aged unsuccessfully (Latimer 1999; Jones 2006), those who may 'overstay' or those whose needs may not fit with the 'proper' pace-focussed tempo.

This study highlights the issue that NHS services such as the AMU in this study are not designed to meet the needs of their core user group, older people (Calnan et al. 2013). The context of the AMU and the discharge decision-making processes that affirm the rigid temporal structure of the

AMU equate to a conveyor belt experience for older people in which they adapt and present themselves as good patient patients in order to better fit, prove their legitimacy to receive optimal care and maintain their identity. As a result, the care received does not acknowledge or uncover patient's concerns or worries and involvement or the sharing of discharge decision-making is far removed from the patient experience.

8.2.5 The impact of AMU discharge decision-making on relatives; collateral damage in the process

Relatives as advocates in the discharge process was a confirmable finding in this study (Procter et al. 2001; Bauer et al. 2009; Popejoy 2011). However, other findings related to the role of relatives in discharge decision-making were not corroborated in this study. For example, relatives being integral to the negotiation of a discharge decision and a discharge process that was acceptable for patients (Roberts 2002; Pearson et al. 2004; Dyrstad et al. 2015). In this study, relatives did not appear able to influence the process of discharge planning or decision-making. Despite their advocating, little influence was observed, instead the weight of their caring role usually increased and often in ways they were not aware of until the patient was home. Some were successful in securing conversation and updates from the teams on the units, but this appeared ad-hoc and dependent on an ability to navigate and negotiate the confusing environment and rigid temporal structure.

In that way, the needs and wishes of relatives and carers were not at the centre-point of health professional's concerns, despite continual acknowledgement of their integral role not just in discharge decision-making but older people's care more generally (N.H.S. Institute for Innovation and Improvement 2011). If discharge decision-making was a battle for health professionals, relatives were the collateral damage, the unintended victims. For the relatives in this study, discharge was highly stressful, not helped by the confusing environment that they negotiated unsupported. In the experiences of relatives, health literacy and a lack of time to be involved (many already busy with jobs and other family commitments) were an issue. This study highlights that the additional stress felt by relatives could be avoided if consulting relatives was an ingrained expectation in the temporal map of discharge decision-making processes and the temporal regularity had the flexibility to allow for these conversations but also allow for the expected outcome of the discharge process to potentially change following these conversations. In the current norms of the unit, knowing if someone has or has not got local relatives is just a binary category that has the potential to move someone closer to discharge readiness. In the pace focussed environment the relational connections and social networks of an individual that impact on an older person's ability to manage at home as they did before and their ability to contribute

to decisions is missed. The relational contexts of patients is ignored as patients' needs are simplified (both by patient's active self-effacement and the oversimplification of need by health professionals working within the unit's pace-focussed rhythm). Relatives as potential allies in the process of moving patients through the unit in line with the pace agenda is lost and instead they become collateral damage.

8.3 Methodological reflections and quality of the study

One conclusion from the review of literature in chapter four was that research that used several methods with a naturalistic component was required to unpick the complex process of discharge decision-making. Here, the strengths and weaknesses of this study will be discussed.

Firstly, taking an ethnographic approach to this study ensured that the complexity of the issue of discharge decision-making for older people could be understood. This has led to providing useful insights on the context of the AMU as a whole which, if missing, would have hampered the interpretations of findings relating to discharge decision-making. The ethnographic approach has also allowed for different points of view to be visible from different voices as well as from different time points across two phases of data collection.

Another strength of the study was that it tackled a clinical context within which it is fundamentally difficult to do research. The frenetic AMU often felt like the true front line of the hospital. The AMU is not a ward and nor is it the ED. As such, previous research relevant to both ED environments and hospital ward environments have been relevant. In the AMU it was often impossible to predict the actual journey a person would take. Sometimes very ill people went home from the AMU (when it would have been expected that they would require a longer inpatient stay), sometimes those people who could go home one day became very unwell the next. This was due to a patient group being difficult to research due to their unpredictable medical needs associated with the aging process and frailty (Ebrahimi et al. 2013). Despite this, ethnography has enabled the untangling of this difficult environment to negotiate (Savage 2000).

The access available in completing this study was defined by the ethical approval awarded. Particularly, gaining the experiences of patients and relatives as well as access to patient's medical records was a problem and an issue experienced by other authors (Patterson et al. 2011). Thus, the whole journey of the discharge planning surrounding individual patients could not be feasibly followed. Instead, different time points from different individuals were gained.

There is longstanding debate regarding how much observation is enough in ethnography. Hammersley and Atkinson (2007) argue for caution in having a balance between prolonged

episodes in the field and time to write up and process what has been seen and for a level of informed time sampling to be employed. In this case, with close supervision and reflection, it was deemed that repetitious findings and field notes were becoming a pattern towards the end of the field work and a level of saturation had been achieved. In addition, the AMU, was fairly uncomplicated to 'time sample' within due to its' expected short length of stay and the rigid temporal structure that made the AMU a 'clockwork' environment (Zerubavel 1981).

This study intended to provide a multidisciplinary perspective on the phenomenon. However, the narratives of acute medicine consultants, pharmacists and social workers were not successfully captured. Acute medicine consultants were however observed in the field and despite both them and the pharmacists being keen to participate initially any further data collection with them was not feasible. Social workers did not have a strong presence in the field. It appeared that if a full social work assessment was required it was likely that this would happen at home following intermediate care team input or when they were transferred to another ward. As such, the lack of social worker narrative in this study did reflect the discharge decision-making process on this unit.

Another potential drawback to the study is that there was often a large swathe of time between patient leaving the AMU and the interview taking place. When this was the case it was at the preference of patient participants and therefore little could be done to avoid it. The time of year could also have contributed as often patients were recruited before Christmas and then did not want an interview until the Christmas festivities had settled down. A level of bias, allowing for the passing of time, may be evident as the details of the patient participants' admission may be lost. However, the use of a number of methods and sources should mean that the effect of any potential bias would be limited.

Determining quality in qualitative research is often considered a challenge due to the large variability of terms and interpretations of terms that exist in different approaches and ontological perspectives (Ballinger 2006). In subtle realism, terminology often associated with quality in the quantitative, realist paradigm is adopted, taking into account it's suitability to the aims, methodology and methods of the research (Mays & Pope 2000). In this subtle realist qualitative work concepts of triangulation, reflexivity, respondent validation and clear methods are used.

8.3.1 Analytic generalisability

Critics from a realist perspective can argue that ethnographic works lack external generalisability as they focus on a specific phenomenon in time, place and context with limited applications to a wider population (Flick 2007). However, through in-depth exploration of a particular

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phenomenon, ethnographers do seek to draw general conclusions in ways that still respect the particularity of the cases they study (Hammersley & Atkinson 2007).

Polit and Beck (2010) discuss three approaches to generalisability; statistical generalisation, analytic generalisation and transferability. The most appropriate claim for this study would be analytic generalisation where conceptualisations of social processes and lived experience have been sought through in-depth scrutiny and higher order abstraction. With rigorous inductive analysis and the implementation of confirmatory strategies (in this case, the use of existing theory and empirical evidence) this study can argue that it has been able to generate authentic generalisable conceptual and theoretical understanding in relation to a specific field of understanding, in this instance acute care for older people (Sally et al. 2009; Polit & Beck 2010). Some may argue against the validity of claiming analytic or theoretical generalisability, and instead prefer a fittingness or transferability approach whereby the author is left to determine the extent to which the findings are applicable to their setting or situation (Mays & Pope 2000; Polit & Beck 2010). This may be more in-keeping with a constructivist ontological approach where relativism is upheld. This study acknowledges that generalisations are made on the basis of having identified some general principle that concerns the phenomenon in question and that valid theoretical generalizations presuppose the existence of valid theories (Sharp 1998).

8.3.2 Reflexivity

In the field of ethnography, two interpretations of reflexivity have existed. One, which constitutes the positivist or realist aim for objectivity, where one is reflexive of the impact one has in the field in a bid to control it (Davies 2008) and another where one discusses and reflects on the role taken within the field for the aim of furthering the understanding of context (Hammersley & Atkinson 2007). I have taken the interpretation that acknowledges my contribution to the social world as well as furthering the description of the context in being explicit about my background and behaviours (see section 5.5 of this thesis) (Brewer 2000; Hammersley & Atkinson 2007).

8.3.3 Respondent Validation

Once all data collection activities were completed a report was sent to all participants who provided their contact details. This included a telephone number, address and email address that participants could use to inform the researcher of their thoughts on the findings to date. This process of seeking respondent validity aimed to establish whether participant's experiences and perceptions are represented accurately, adequately and in fairness in a bid to equalise the relationship between the researcher and the participants (Simons 2009). This is an acknowledged

way of assessing the findings and conclusions and gaining feedback. However, no responses were received. This could be due to patients and relatives having no issues or concerns with the reported information. In likelihood however the length of time between patient and relative interviews and the sending of the report is expected to have impacted upon how invested participants felt in the outcome of the report. In addition as the findings of this study did not wholly rely on their interview data they may have felt fairly far removed from the conclusions or they may have found being asked for their comment unusual especially if they have not taken part in research previously. It is therefore likely that respondent validation was not sought in the most meaningful or effective way in this study.

8.3.4 Triangulation

The triangulation of perspectives, data sources and also temporal triangulation from different phases of data collection can contribute to a level of confidence in reporting findings evident from a range of situations and has been sought in this study (Hammersley & Atkinson 2007).

Triangulation enables a level of checking and confirming between reports and is seen as a qualitative alternative to validity (Mays & Pope 2000; Flick 2007). However, this interpretation of triangulation is seen as a realist interpretation and social research writers have adopted a different explanation using a crystal as a metaphor, where data is viewed from different angles (Richardson 1997; Ellingson 2013). Using the crystal metaphor, triangulation becomes presenting and considering alternative ways of viewing meaning from different angles and perspectives in order to illicit an in-depth picture (Simons 2009). This project has aimed to provide a credible and in-depth understanding by using a range of perspectives and data collection methods to understand the phenomenon.

Despite some of the potential study limitations as discussed above, this study provides novel contributions on how discharge decisions occur in the acute medical unit and provides insight into the impacts of these practices on older people, patients and relatives. It also adds theoretical insights on the impact of bureaucratically driven pace-focussed organisational structures on concepts related to person-centred care.

8.4 Discussion summary and recommendations for future work and thinking

This study has identified that the shared decision-making policy recommendations are not evidenced in the AMU at the centre of this study. The bureaucratically driven rigid temporal

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structure of the unit is adapted to and reinforced by health professionals serving to meet the pace focussed tempo and older people attempting to mould themselves to better fit (Figure 15).

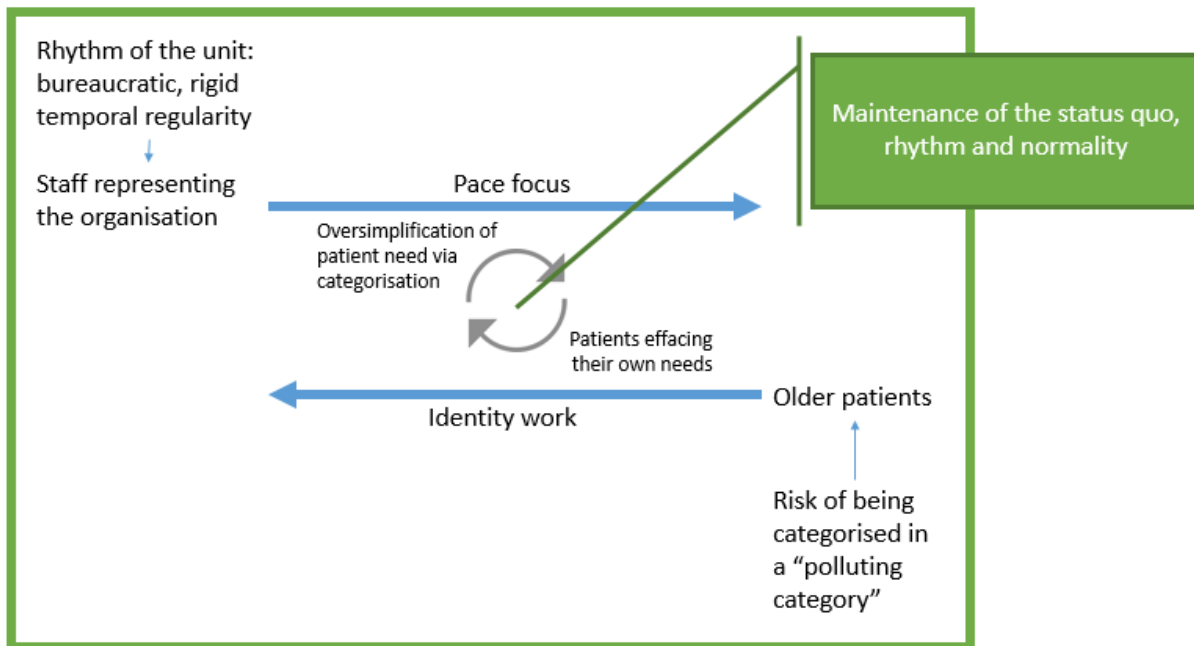


Figure 15 Imperishable norms of the AMU for older people

The pace focus of the AMU punctuates the experiences and behaviours of all those involved. Relatives, patients and health professionals adapt in order to fit with the organisation's priority. As shown in figure 15, two opposing forces, one led by hospital staff representing the organisation and the other led by older patient's legitimacy concerns and identity work reinforce and maintain the rhythm of the unit.

This study adds to a body of work, which recommends that organisations pull the focus away from pure organisational need, or as identified in this study, break the current norms of pace focussed rigid structure and encourage a level of temporal flexibility that can cater to the complex and unpredictable needs of older patients, not just in reiterating the need to tailor care to individual need but also in acknowledging that all people, but specifically older people, are inter-dependent beings influenced in decision-making processes by what they see around them and those with whom they relate. The current policy messages are not sufficient. Societal expectations that we are all individuals independent of one another and completely autonomous in all decisions we make is not workable in the chaotic, pressurised, rushed and pace-focussed environment of the AMU. Policy messages for shared decision-making at least acknowledge interdependence and the need for support to contribute to decisions but have, thus far, failed to have influence in the pace focus acute services. The borders of figure 15 depict the fact that the current norms on the unit are not easily permeated by continual recommendations for shared decision-making. In the same

way that the norms are not easily permeated by the complexity or temporal anomalies that older people may present with as patients.

Durocher et al. (2015) interpreted their data through the theory of relational autonomy. Relational autonomy, as discussed earlier in this thesis, positions autonomy as a competency that considers the influence of social networks and interdependence of individuals with each other as grounds for which decisions are made (Sherwin & Winsby 2011). The findings of this study, further the argument for a change of culture to older people's care and acute care that uses the theory of relational autonomy to understand how decision-making should be supported. If practice were underpinned by relational autonomy it may be that health professionals would have the "space" to deal with the ethical implications of discharge planning in a way that captured the needs, wants, preferences and wishes of patients and meaningful input from their relatives, thus more representative of shared decision-making (Durocher et al. 2015). If organisations were designed with relational ethics underpinning them and a focus on the relational aspects of care, rather than the economic-utilitarian philosophy discussed in the findings of this study, they may better serve the needs of the people that use them most, older people (Calnan et al. 2013).

Similar calls for a change in the culture of care have had broader causes than decision-making and discharge within nursing research. Underpinned by research that confirms Williams et al.'s (2009) 'Pace-Complexity dynamic' theory that care focussed on pace does not result in the person-centred care, other studies have also called for a change in approach to care that is focussed on relationships to improve experiences (Nolan et al. 2006; Bridges et al. 2010; Patterson et al. 2011; Maben et al. 2012). Proposals for culture change initiatives that enable teams, wards or units to participate in the creation of 'enriched environments' for change and improvements in experiences are already in existence (Dewar & Nolan 2013; Bridges & Fuller 2015). Initiatives that seek to promote person-centred working cultures in favour of task-focussed healthcare are also recommended in the context of improving patient safety and dignity in acute environments (Calnan et al. 2013; Dixon-Woods et al. 2014). It will remain to be seen if such initiatives are able to permeate the current bureaucratic temporal rigidity that drives the culture of clinical units in the English NHS, as undoubtedly conceptual and temporal "space" will be needed in order for improvements to be successful.

In tackling the lack of "space" identified in this study, some simple changes could be adopted. A protected physical space for discussions such as discharge decision-making discussions to occur in private and in quiet that was easily accessible would be of benefit. An organisational expectation set out in official policy but moreover instilled in the care received is also required but it would need to achieve at least parity of importance with the achievement of some of the quantitative

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and financial incentives that currently shape the way care is enacted (four hour ED target, didactic length of stays, KPIs shaped around response time etc.) More than a tick-box paperwork approach, workshops and interactive trainings that discuss the varying ways in which decisions can become shared decisions could potentially begin to assist staff members in infiltrating the current status quo of full commitment and adaptation to the pace focussed temporal structure.

Coulter and Collins (2011) make a number of recommendations to improve shared decision-making including the identification of decision points in care pathways and the monitoring of the quality of shared decision-making. This recommendation may be helpful in allowing health professionals to pinpoint key moments that occur as moments when a shared decision-making opportunity has been missed, but the monitoring of quality of shared decision-making is more difficult when discharge decision-making in the care of older people is multi-faceted, complex and difficult to define. A call is also made for inclusion of the subject in training and promoting the recording of and support for shared decision-making (similar to the aforementioned recommendation of making it known and public that shared decision-making is an organisational expectation) (Coulter & Collins 2011).

Coulter and Collins (2011) also recommend incentivising shared decision-making behaviours. Existing incentives, preventing breaches of the ED four hour target for example, only serve to bolster the organisational drivers and have potentially negative knock on affects further along the patient pathway, as the findings in this study and others suggest (Campbell et al. 2017). It is not possible to draw conclusions about whether patient centred incentives would also have problematic issues with their effect and their enactment. However another incentive even with a patient-centred focus, could easily be reduced to an over simplified tick box exercise as much of the routinely used paperwork on the AMU already suggested in this study.

Shared decision-making literature to date has concluded that change initiatives have to be more than decision-making tools (Joseph-Williams et al. 2017). Education has a crucial role in promoting the need for shared decision-making (Elwyn et al. 2012; Joseph-Williams et al. 2017). Elwyn et al. (2012) created a simplified model of shared decision-making to aid in the teaching of the concept. It identifies three different types of discussion; choice talk (involving stepping back, offering choice, justifying choice, checking reaction and deferring closure), option talk (involving checking knowledge, listing options, describing options and exploring preferences, providing harms and benefits, providing decision support, summarising) and discussion talk (focussing on preferences, eliciting preferences, moving to a discussion and offering review). Elwyn et al. (2012) also calls for methods of education that are experiential, using the model as a guide.

Other options to raise the profile of a concept or issue such as shared decision-making is social media. Social media campaigns have served as one avenue to promote messages and evoke change for health professionals in the NHS and healthcare more widely³⁴. Simple initiatives designed to improve aspects of care, often towards a focus back on relational or person-centred approaches have appeared successful although the extent of this has not been formally measured or explored in research.

At a societal level however, this project has highlighted some wider debates and questions that are needed regarding the public expectations on the English NHS. It is unhelpful to initiatives such as involvement, shared decision-making and relational approaches to care if policy and public message continues to embrace the western rhetoric that frames independence and autonomy as the ideal and continues to commit to consumerism, capitalism and utilitarianism. This ideal is not feasible for older people with complex health and care needs who will need to depend on someone or something, even just for reassurance rather than actual physical assistance. Relational ethics and relational approaches to autonomy would better reflect older people's experience of health and care.

AMUs in the NHS, even if re-focussed slightly, will always have an inherent pace focus. It therefore needs wider discussion nationally as to whether it is realistic or necessary for concepts such as shared decision-making to be experienced in acute environments. If policy trends closer to privatisation or consumerism, it may be that needs of people that do not fit with the western ideals of independence and control of one's own health and wellbeing become more problematic for NHS services. Further research is required to provide evidence for or against the common preconception that shared decision-making and increasing patient involvement will always take up more time and resources or that financial incentives are the only way for efficiency to improve (Elwyn et al. 2012; Campbell et al. 2017).

The outcome of current research programmes promoting enriched environments, compassionate and relational approaches to care need to be monitored to establish if these can successfully penetrate the current norms and build temporal flexibility to allow the needs of older people to be adequately considered and met (Williams et al. 2009; Dewar & Nolan 2013; Bridges & Fuller 2015). Further research into education programmes and their effect on the uptake of shared decision-making would also be beneficial. Following the insights gained from this study it is likely that a participatory approach to this type of research would be beneficial given the complexity

³⁴ Campaigns such as #HelloMyNameIs and #Last1000Days have had many 'hits' and 'impacts' on social media as health professionals debate how care can be improved. See <http://www.last1000days.com/> and <https://hellomynameis.org.uk/>

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and multi-faceted nature of discharge decision-making and older people's care. Specific to discharge decision-making further definition is required of what shared decision-making should look like in contexts that will always have a degree of pace underpinning them. It would be of benefit for this to be co-produced by older people's care experts, patients, relatives and clinicians to aid in the ease of translation into practice.

In summary, the current culture of the AMU does not engender person-centred care approaches for older people. The bureaucratic rigid temporal regularity ensured that all actors in the field were focussed on pace. Fast-pace has become the 'proper' tempo on the AMU. Working within this context, health professionals seek out simple discharges by not capturing the complexity of older people's needs and using oversimplified categories to progress them towards discharge. By doing this they maintain this rhythm. When the rhythm is interrupted, health professionals are faced with difficulty, discomfort and a battle. In interpreting this context, older people minimise their own needs to ensure they 'fit' within the system and ensure they are not consigned to a polluting category such as an 'overstayer'. Mrs Andrews' quote below illustrates this best and in the dissemination of this work has served as thought-provoking discussion point;

“they probably didn't realise how I really felt because I, I wasn't chatting [to] them, they're so busy, I wouldn't have chatted [to] them about myself.”

This thesis has identified the following recommendations for further work and thinking.

Recommendation 1: Consideration by policymakers for policy to move away from language and ideas synonymous with “control”, “choice” and “autonomy” and towards more inclusive policy acknowledging “relational autonomy” that is more representative of the lived experience of older people, the main users of acute hospital care.

Recommendation 2: An open and public discussion between policymakers, experts and clinicians, regarding the organisational commitment to utilitarian-economic philosophy on time in the English NHS and the associated financial and time focussed incentives and targets that shape the way care is organised.

Recommendation 3: Further research on approaches to improvement in acute care and alternative approaches to ensuring quality and efficiency that do not make upholding the rhythm of pace the main priority.

Recommendation 4: Research addressing how an organisational culture shift towards the relational aspects of care can be achieved, including exploring existing attitudes towards these ideas at an organisational level.

Recommendation 5: Specific definition of what shared decision-making in discharge planning for older people in acute care should look like, co-created by all stakeholders (patients, relatives, professionals from health and social care and policy-makers).

Recommendation 6: Research addressing whether education initiatives, such as space for open reflection and participatory workshops, can have an impact on shared decision-making in discharge planning. This will require a workable definition first.

Recommendation 7: For Higher Education Institutions to ensure shared decision-making as a concept is covered in all health professional's undergraduate training in a meaningful and participatory way to promote the concept and enable it to become more of a part of the norms of working in health and social care.

Appendices

Appendix A Dissemination activities

Publications;

- Rule A, Adams J and Bridges J (2017) 137 Discharge decision-making for Older People in the Acute Medical Unit - an Ethnographic Study *Age and Aging* 46 (suppl_1):i35-i38
- Rule A (2015) Review: On discharge planning: dynamic complex processes – uncertainty, surprise and standardisation *Journal of Research in Nursing* 20(1):54-5
- Rule A, Bridges J and Adams J (2015) Discharge decision-making for older people. A review of the literature using a qualitative synthesis. IN Craik C (ed) College of Occupational Therapists 39th Annual Conference & Exhibition Brighton 30th June – 2nd July 2015 *British Journal of Occupational Therapy* 78 (Supplement 8):1-131
- Rule A (2014) Key issues for older people's discharge *OT News* September 2014 P.27

Awaiting Publication;

Book Section; 'An occupational therapist ethnographer on an Acute Medical Unit; using reflexivity to understand situational identities and the weight of expectation.' IN Milton S, Garnett E and Reynolds J (pending) *Ethnographies and Health: Reflections on Empirical and Methodological Entanglements*. Palgrave

Due for publication June 2018.

Published abstract; Rule A, Collins P and Bridges J (2018) INVOLVING OLDER PEOPLE IN THEIR DISCHARGE FROM HOSPITAL - A SYSTEMATIC QUALITATIVE SYNTHESIS *Age and Aging*

Confirmed for publication

Paper and poster presentations;

Please note; this list does not include dissemination activities that have taken place to research groups and clinical teams across the University of Southampton, Wessex CLAHRC, Portsmouth Hospitals NHS Trust, Southern Health NHS Trust, Imperial College Healthcare NHS Trust and The Royal Marsden NHS Trust

Date	Type of presentation	Title	Event	Other information
November 2017	Involving older people in their discharge home; a systematic qualitative synthesis	Poster	The British Geriatrics Society Autumn meeting 2017, ExCell centre, London	
September 2017	Discharge decision-making in the Acute Medical Unit for	Oral presentation	Research Symposium, The Clinical Academic Training Office,	Awarded best abstract

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	older people		Imperial College, London	
November 2016	Discharge decision-making for older people on the Acute Medical Unit	Poster presentation	The British Geriatrics Society Autumn Meeting 2016, The SECC, Glasgow	
May 2016	Exploring the Disconnection between policy recommendations and current experiences of discharge decision-making for older people	Oral presentation and panel discussion	Everyday Ethics Conference, Royal College of Nurses, London	Presentation video available via link; https://www.youtube.com/watch?v=mmcarPShTKU&feature=youtu.be
March 2016	Discharge decision-making for older people	Three Minute Thesis Presentation	Faculty of Health Sciences, Three Minute Thesis Heat.	Faculty runner up
October 2015	A reflection on the use of an ethnographic case study to understand the hospital discharge decision-making process for older people	Oral presentation	Ethnographies and Health Early Career Researchers Workshop, London School of Health and Tropical Medicine.	
June 2015	Discharge decision-making for older people – an ethnographic case study.	Oral presentation	Faculty of Health Sciences Postgraduate Research conference, University of Southampton	Awarded best paper presentation
July 2015	Discharge decision-making for older people. A review of the literature using a qualitative synthesis	Oral presentation	College of Occupational Therapists 39th Annual Conference & Exhibition, Brighton	
May 2014, June 2014 and July 2015	Proposed research methods	Poster presentation	College of Occupational Therapists 39th Annual Conference &	Awarded best paper at Celebrating Best Care conference

			<p>Exhibition, Brighton, Portsmouth Hospitals NHS Trust Celebrating Best Care conference, Faculty of Health Sciences Postgraduate Research conference, University of Southampton</p>	
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Appendix B Email to hospital staff

Dear members of staff on the MAU,

Re: Research project to commence November 2014

I am writing to inform you of a research project that is due to take place at the [site, hospital]. I am a clinical academic PhD student from the University of Southampton and the research will form part of my PhD project.

Using observations and interviews, I am planning to research discharge decision-making for older MAU patients between 11/11/2014 and 31/04/2015. This email provides information about the study plans and explains how you can get more information and/or raise any concerns about the plans.

Research title:

The process of discharge decision-making for older people returning to the community from a general hospital short stay unit: a case study.

What will this involve?

- Interviews with patients over 65 and relatives
- Observation of discharge discussions with patients and/or relatives, observation of initial nursing assessments, observation of medicine for older people ward rounds and observation any other aspect of patient care that is relevant to the discharge planning and decision-making process
- Analysis of relevant sections of patient notes regarding discharge plans
- Focus groups with health professionals, these will be organised at a later date and you will be invited to these closer to the time

Why do this research?

The aim of the research is to understand the process of discharge decision-making in this complex and time pressured environment.

What do I need to do?

You should carry on working as normal throughout the research. I may ask you questions about patients to ensure they are suitable for inclusion in the research, and I will tell you which patients are included in the study. If patients are being interviewed, I will take them from their ward space to the interview room, relative room or meeting room for their

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interviews, which should not be longer than an hour. I will ask permission for this from the nurse looking after each patient. I may also observe you and your colleagues as you go about your work but the research should not disrupt your day to day work on the MAU. I will not interrupt or interfere with patient care. I will endeavour to ensure as little burden as possible is felt by staff or patients during data collection.

What if I don't want to take part?

If you do not wish to be included in the observation aspect of this research, please contact me (details at the bottom of this email). If you choose not to be included it will not affect your work or your legal rights.

This research is not intended to criticise the hard work of hospital staff, it aims to understand the process of discharge decision-making in this complex environment. Most aspects of the research will remain confidential throughout and you will not be identifiable from the research report. If you have any questions please do not hesitate to contact me. In the unlikely event that something is observed that suggests unacceptable or unsafe practice; I will be required to report this matter locally. I will discuss this with you and will explain what will happen. This is designed to safeguard patients.

Attached is a copy of the research poster that will be displayed around the unit, this also contains my contact details should you require them at any point along the process.

Many thanks for your co-operation.

Best wishes,

Annabel Rule

Clinical Academic PhD student

07845408002

ar17g09@soton.ac.uk

Supervised by Jackie Bridges (Jackie.Bridges@soton.ac.uk) and Jo Adams (ja@soton.ac.uk)

Appendix C Research poster

RESEARCH STUDY: Discharge Decisions for older people from hospital to the community

Occupational Therapist Researcher Annabel Rule aims to explore how discharge decisions are made during older people's stay in the Medical Assessment Unit for a University research project.

WHO CAN HELP?

People aged 65 and over who are staying on the Medical Assessment Unit or MAU and their relatives or carers



The research will involve:

- Observing a person's care in hospital
- Interviewing that person
- Interviewing their relative or carer
- Confidentially analysing the person's hospital notes
- Carrying out a focus group for hospital staff

If you'd like to be involved, know someone who would or would like more information please contact Annabel Rule.

Email: ar17g09@soton.ac.uk Phone: 07XXXXXXXXXX

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Southampton

Appendix D Observation framework

Patient's pseudonym:	Date: Time:
Brief Description of observed event:	
Who is present?	
Observations about communication:	
Observations of environment:	
Was a decision made? Who made it? How?	
Other observations:	

Appendix E Summary information sheet; patient



Trust Logo

The discharge decision-making process for older people returning to the community from a general hospital short stay unit

You are invited to take part in a local project that aims to identify how discharge decisions are made for people over 65 on this ward (the MAU). It aims to understand who makes these decisions and how the decision-making process is experienced.

It is your choice whether you take part or not and you are welcome to decline.

If you choose to take part the researcher, Annabel Rule, will interview you in a private place near the ward. She will ask you about your experience and expectations of your hospital stay so far with a focus on your discharge home.

She will also observe the hospital staff and how they talk to you about your discharge. She will take notes throughout.

She will then analyse a relevant portion of your hospital notes, to see how the hospital staff write about their plan for your discharge.

Annabel will ask to interview you again about your experiences in hospital when you are home.

Annabel will also ask if you have a carer or relative who may also want to be involved in the project.

The care you receive in hospital will not be affected if you take part. You can leave the study at any time.

All of your information will be anonymous throughout. You will be asked to choose a pseudonym.

The study is being funded by [funding Trust] and the University of Southampton with permission from [this Trust].

Annabel can provide you with more information if you would like. If you choose to take part, Annabel will ask you to sign a consent form.

Please feel free to ask any questions. THANK YOU FOR YOUR TIME

Appendix F Supplementary information sheet; patients

SUPPLEMENTARY PATIENT PARTICIPANT INFORMATION

Study title: The process of discharge decision-making for older people returning to the community from a general hospital short stay unit – a case study.

Researcher: Annabel Rule

Contact details: Annabel Rule, University of Southampton, Building 45, University Road, SO17 1BJ. 07XXXXXXXXX ar17g09@soton.ac.uk

- I would like to invite you to take part in this research study. Please read all of the information below before deciding whether you would like to take part or not.
- If you have any questions, please do not hesitate to ask. If you do decide to take part, I will ask you to fill in a consent form.
- This research is being funded by Southern Health NHS Foundation Trust with permission from [this Trust] and has been approved by the University of Southampton
- For your safety this research has been approved by the Yorkshire and Humber NHS Ethics committee. Please ask for more information about this if you would like it.

WHAT IS THE RESEARCH ABOUT?

This research is part of a research project which once completed will contribute towards completion of my PhD (a research degree) at the University of Southampton. I am interested in the way that discharge decisions are made when people are in hospital. I am focussing on people who are 65 and over, how the decisions are made, who makes them and how the decision-making process is experienced. I would like to know your experiences and thoughts, as well as your family or carer's and that of the hospital staff. Once you have been discharged I'd like to come and visit you to ask how your time in hospital has been. I will also want to know what you felt your role was in the discharge decision-making process.

I have approached you because you have recently come on to the Medical Assessment Unit and are over the age of 65.

DO I HAVE TO TAKE PART?

You do not have to take part in this research. It is up to you to decide. This information sheet will explain all of the details and you can ask the researcher anything if you are unsure. I will give you as much time as you need to decide. If you do want to take part I will ask you to sign a consent form. Once this form has been signed, you can still change your mind about taking part at any time. You do not need to give a reason for why you want to stop. Taking part or not taking part in this study will not change the care you receive at hospital. Your care will remain the same.

WHAT WILL HAPPEN IF I TAKE PART?

- If you choose to take part I will ask you to take part in an interview. This will happen in a meeting room on this ward. I can point this out to you if you ask. You can choose to have someone with you at this time if you would like.
- The interview will be recorded on a tape. The interview can be stopped at any time and you do not need to answer any questions if you do not want to. What you say will be written up and analysed as part of the research. The written report of your interview will be anonymous. No one will know what you have said apart from the researcher. You can choose a false name under which your interview information will be kept. The information you share will only be used for this study.
- If you have a relative or carer who is with you or is likely to come to see you in the hospital the researcher will want to ask them if they would like to take part too. If they choose to join in, a separate interview will be arranged with them – although if you like, they can also sit in on your interview as well.
- The interviews will not have an impact on your care.
- As well as interviewing you I will be observing things happening on the ward. I will be observing the conversations that you have with staff about your discharge including any assessment that they do. I will be focussed more on the staff than you the patient. I will not interrupt or interfere with your care. I may write some notes during this time.

- I would also like to look at what the hospital staff write down in your medical notes. These notes will have all of your personal data (e.g. name) removed from them before analysis. I will analyse these and they will only be used for this research. I will only look at relevant sections of your notes. While you are in the hospital I may ask you a few clarifying questions and note down your responses about what the plan is for your care and what your thoughts are. Once you have been discharged from the hospital I will arrange to carry out another interview, this can either be in your home or back at the hospital, whichever is easier for you. If the researcher interviewed your relative or carer it would be good for them to be there too. You are welcome to have anyone else there at the time of interview if you would like.

ANONYMITY

You will be asked to choose a different name for yourself by which the information associated with you will be kept under. Your relative or carer if interviewed will also have different names. The hospital staff will also be given different names. No one will be able to identify you from the information or final report. Your personal information (e.g. your name) will be locked away at the University of Southampton for 10 years before being destroyed.

WHAT ARE THE BENEFITS OF TAKING PART?

The study will not affect the care that you receive in hospital.

The results of the study may help to improve services to make things better for people like you in the future.

The research will help towards the completion of my university course.

ARE THERE ANY DRAWBACKS TO TAKING PART?

There are no real harms in taking part in this study. I will make sure to give you respect and dignity at all times as is hospital policy. Your care will remain the same as if you were not in the study. It may be that you feel uncomfortable or upset at some point during the study. I will be patient, supportive and sympathetic if this is the case and will help to identify where you can get some further help if you need or want it.

You have the right to withdraw from the study at any time and this will not affect your rights or the care that you receive.

WHAT HAPPENS TO THE RESULTS?

You have the opportunity to receive the final report of the research findings if you would like it. The study report will be submitted as part of my PhD papers. I may get the opportunity to present the findings at conferences or publish them in academic journals.

CONTACTS

If you have a concern or complaint about this study, do not hesitate to contact:

<u>Research Governance Manager</u>	
Research Governance Office Building 37 University of Southampton Highfield Campus Southampton SO17 1BJ	02380 595058 rgoinfo@soton.ac.uk

If you would like more information you can contact the researcher direct:

Annabel Rule

email: ar17g09@soton.ac.uk phone:07XXXXXXXXXX

<u>Academic Supervisors</u>	
<u>Jo Adams</u>	<u>Jackie Bridges</u>
Phone: 02380 595287 Email: ja@soton.ac.uk	Phone: 02380 598282 Email: Jackie.Bridges@soton.ac.uk

Appendix G Consent form for patients

CONSENT FORM - Patient

Title of Project: The Process of discharge decision-making for older people returning to the community from a general hospital short stay unit – a case study

Name of Researcher: **Annabel Rule**

Please initial the boxes if you agree with each section

1. I confirm that I have read and understand the information sheet dated **23/06/2014** (version 4) for the above study.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I agree that a tape recording will be made of my interview(s). I understand that this recording will be heard by no one else, that it will be labelled so that I cannot be identified, and that it will be destroyed when the research is complete.

4. I agree that notes will be made during observations of my care. I understand that no one else will have access to these notes outside of the research team and that they will be recorded so that I cannot be identified.

5. I give permission for the researcher to have access to my ward based hospital paper record that contains information relevant to my hospital stay so that she can use **only relevant passages** as part of the research. I understand that these will be written out in the researcher's notes so that I cannot be identified, and that these passages will not be looked at by anyone outside of the research team.

6. I agree to take part in the above study.

7. I would like a summary of the findings when the research has been completed:

Yes / No (please circle)

If you would like a copy of the findings, please write you address/email address clearly here:

Name of Participant	Signature	Date

Name of Person taking consent	Signature	Date

Appendix H Summary information sheet; relatives



Trust Logo

The discharge decision-making process for older people returning to the community from a general hospital short stay unit

You are invited to take part in a local project that aims to identify how discharge decisions are made for people over 65 on this ward (the MAU). It aims to understand who makes these decisions and how the decision-making process is experienced.

You have been invited because your relative or a person you care for is currently a patient on the MAU.

It is your choice whether you take part or not and you are welcome to decline.

If you choose to take part the researcher, Annabel Rule, will interview you in a private place near the ward. She will ask you about your experience and expectations of your hospital stay so far focussing on the decision-making and planning of your relatives' discharge.

She will then observe the hospital staff and how they talk to the patient about their discharge and if and how they talk to you too. She will take notes throughout.

Annabel will ask to interview you again about your experiences in hospital once your relative is home. You can do this separately or together, whatever is your preference.

The care your relative or the person you care for receives in hospital will not be affected if you take part. You can leave the study at any time.

All of your information will be anonymous throughout.

The study is being funded by [funding Trust] with permission from [this Trust] and the University of Southampton.

Annabel can provide you with more information if you would like. If you choose to take part, Annabel will ask you to sign a consent form.

Please feel free to ask any questions.

THANK YOU FOR YOUR TIME

Appendix I Supplementary information sheet; relatives

SUPPLEMENTARY RELATIVE PARTICIPANT INFORMATION

Study title: The Process of discharge decision-making for older people returning to the community from a general hospital short stay unit – a case study.

Researcher: Annabel Rule

Contact details: Annabel Rule, University of Southampton, Building 45, University Road, SO17 1BJ. 07XXXXXXXX ar17g09@soton.ac.uk

- I would like to invite you to take part in this research study. Please read all of the information below before deciding whether you would like to take part or not.
- If you have any questions, please do not hesitate to ask. If you do decide to take part, I will ask you to fill in a consent form.
- This research is being funded by Southern Health NHS Foundation Trust with permission from [this Trust] and has been approved by the University of Southampton
- For your safety this research has been approved by _____ NHS Ethics committee. Please ask for more information about this if you would like it.

WHAT IS THE RESEARCH ABOUT?

This research is part of a research project which once completed will contribute towards completion of my PhD or research degree at the University of Southampton. I am interested in the way that discharge decisions are made when people are in hospital. I am focussing on people who are 65 and over, how the decisions are made, who makes them and how the decision-making process is experienced. I would like to know patient's experiences and thoughts, your thoughts and those of the hospital staff. Once your relative has been discharged I'd like to come and visit you to ask how their time in hospital has been. I will also want to know what you felt your role was in the discharge decision-making process.

I have approached you because your relative or the person you care for has recently come on to the Medical Assessment Unit and they are over the age of 65.

DO I HAVE TO TAKE PART?

You do not have to take part in this research. It is up to you to decide. This information sheet will explain all of the details and you can ask the researcher anything if you are unsure. I will give you as much time as you need to decide. If you do want to take part I will ask you to sign a consent form. Once this form has been signed you can still change your mind about taking part at any time. You do not need to give a reason for why you want to stop. Taking part or not taking part in this study will not change the care you and your relative or the person you care for receive at hospital. The care will remain the same.

WHAT WILL HAPPEN IF I TAKE PART?

- If you choose to take part, the researcher I will ask you to take part in an interview. This will happen in a meeting room on this unit. I can point this out to you if you ask. You can choose to have someone with you at this time if you would like.
- The interview will be recorded on a tape. The interview can be stopped at any time and you do not need to answer any questions if you do not want to. What you say will be written up and analysed as part of the research. The written report of your interview will be anonymous. No one will know what you have said apart from the researcher. The information will only be used for this study.
- The patient will also be interviewed similarly.
- As well as interviewing you I will be in the hospital observing. I will be observing the conversations that you or the patient have with staff about discharges including any assessment that they do with the person you care for. I will be focussed more on the staff than you or the patient. I will not interrupt or interfere with care that is given. I may write some notes during this time.
- While the person you care for is in the hospital I may ask you a few clarifying questions and note down your responses about what the plan is for their care and what your thoughts are. Once your relative has been discharged from the hospital, I will arrange to come and visit your home to carry out another interview. If you would prefer, the interview can occur at the hospital and we can refund any travel costs. You are welcome to have

anyone else there at the time of interview if you would like. You and the patient can do this interview together or separately. **ANONYMITY**

You will be referred to in the research by a different name, as will the patient and the hospital staff. No one will be able to identify you from the information or final report. Your personal information (e.g. your name) will be locked away at the University of Southampton for 10 years before being destroyed.

WHAT ARE THE BENEFITS OF TAKING PART?

The study will not affect the care that you or the person you care for receives in hospital.

The results of the study may help to improve services to make things better for people like you in the future.

The research will help towards the completion of my university course.

ARE THERE ANY DRAWBACKS TO TAKING PART?

There are no real harms in taking part in this study. I will make sure to give you respect and dignity at all times as is hospital policy. Your care will remain the same as if you were not in the study. It may be that you feel uncomfortable or upset at some point during the study. I will be patient, supportive and sympathetic if this is the case and will endeavour to identify where you can get some further help if you need or want it.

You have the right to withdraw from the study at any time and this will not affect your rights or the care that you receive.

WHAT HAPPENS TO THE RESULTS?

You have the opportunity to receive the final report of the research findings if you would like it. The study report will be submitted as part of my PhD papers. I may get the opportunity to present the findings at conferences or publish them in academic journals.

CONTACTS

If you have a concern or complaint about this study, do not hesitate to contact:

<u>Research Governance Manager</u>	
Research Governance Office Building 37 University of Southampton Highfield Campus Southampton SO17 1BJ	02380 595058 rgoinfo@soton.ac.uk

If you would like more information you can contact the researcher direct:

Annabel Rule – email: ar17g09@soton.ac.uk phone:07XXXXXXXXXX

<u>Academic Supervisors</u>	
<u>Jo Adams</u>	<u>Jackie Bridges</u>
Phone: 02380 595287 Email: ja@soton.ac.uk	Phone: 02380 598282 Email: Jackie.Bridges@soton.ac.uk

Appendix J Consent form; relatives

CONSENT FORM – Relative or Carer

Title of Project: The Process of discharge decision-making for older people returning to the community from a general hospital short stay unit – a case study

Name of Researcher: **Annabel Rule**

Please initial the boxes if you agree with each section

1. I confirm that I have read and understand the information sheet dated **23/06/2014** (version 4) for the above study.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my relative's or the person I care for's medical care or legal rights being affected.

3. I agree that a tape recording will be made of my interview(s). I understand that this recording will be heard by no one else, that it will be labelled so that I cannot be identified, and that it will be destroyed when the research is complete

4. I agree to take part in the above study.

5. I would like a summary of the findings when the research has been completed:
Yes / No (please circle)

If you would like a copy of the findings, please write your address/email address clearly here:

Name of Participant

Signature

Date

Name of Person taking consent

Signature

Date

Appendix K Interview guide for patients

Introductory:

Remind interviewee of purpose of research and introduce self. Remind interviewee that all information remains confidential, and that they are free to withdraw at any time.

Questions:

1. How have you been managing since leaving hospital?
 - How has it been being back?
2. What happened when you left hospital?
3. When was the decision made that you would leave hospital?
4. Who made that decision?
 - How did they make that decision?
5. Did you have a role in making that decision?
 - What did you do to help?
6. How did your relative/carer help in the decision-making?
 - What was their role?
7. What information did you receive while in hospital?
8. How were you prepared to go home?
9. How did the hospital staff communicate the discharge plan to you?
10. What advice would you give to another patient who has just arrived on MAU regarding discharge?
11. How would you make the discharge decision-making process better for patients?
 - Would you provide information, if so what?
12. What would you change about how your discharge decision was made?
 - How would discharge decisions be made in an ideal situation

Appendix L Interview guide for relatives

Introductory:

1. Remind interviewee of purpose of research and introduce self. Remind interviewee that all information remains confidential, and that they are free to withdraw at any time.

Questions:

1. How has your relative been managing since leaving hospital?
2. What happened when your relative left hospital?
3. When was the decision made that your relative would leave hospital?
4. Who made that decision?
 - How did they make that decision?
5. Did you have a role in making that decision?
 - What did you do to help?
6. How did your relative help in the decision-making?
 - What was their role?
7. What information did you receive while in hospital?
8. How were you prepared for your relative to leave hospital?
9. How did the hospital staff communicate the discharge plan to you?
10. What advice would you give to another patient who has just arrived on MAU regarding discharge?
 - What advice would you give to that patient's family members?
11. How would you make the discharge decision-making process better for patients?
 - Would you provide information, if so what?
12. What would you change about how your discharge decision was made?
 - How would discharge decisions be made in an ideal situation?

Appendix M Information sheet for group interview

Hospital Staff participant research information pack

Study title: The Process of discharge decision making for older people returning to the community from a general hospital short stay unit – a case study

Researcher: Annabel Rule

Contact details: Annabel Rule, University of Southampton, Building 45, University Road, SO17 1BJ. Research phone: 07845408002 Email: ar17g09@soton.ac.uk

I would like to invite you to take part in this research study. Please read all the information below before deciding whether you would like to take part or not.

If you have any questions, please do not hesitate to ask. If you do decide to take part, I will ask you to fill in a consent form.

This research is being funded by Southern Health NHS Foundation Trust with permission from [this Trust] and has been approved by the University of Southampton

For your safety this research has been approved by Yorkshire and the Humber NRES ethics committee. Please ask for more information about this if you would like it

WHAT IS THE RESEARCH ABOUT?

This research is part of a PhD research project at the University of Southampton. I am interested in the way that discharge decisions are made when people are in hospital. I am focussing on people who are 65 and over, how the decisions are made, who makes them and how the decision making process is experienced in the MAU. I would like to know your experiences and thoughts, that of the patient as well as the experiences and thoughts of the patient's relatives or carers. I would also like to find out the experiences of patients and relatives once the patient is home.

WHY HAVE I BEEN INVITED TO TAKE PART?

You have been invited because you work on the MAU and have been identified to have a pivotal role in the discharge decisions made for older people on the MAU.

DO I HAVE TO TAKE PART?

You do not have to take part in this research. This information sheet will explain all of the details and you can ask the researcher anything if you are unsure. If you do want to take part please complete the attached consent form and return it to the researcher. Once this form has been signed you are still allowed to stop taking part at any time. You do not need to provide a reason for why you want to stop.

WHAT WILL HAPPEN IF I TAKE PART?

If you choose to take part, the researcher, Annabel Rule, will invite you to take part in a focus group with other staff. This group interview will happen for an hour over a lunch time on the hospital site. You will have a choice of times so that you can pick the most convenient for you. Other hospital staff that have a pivotal role in discharge decision making will also be invited to be in the focus group.

Topics covered during the focus group will include; older people's and their relatives' experiences of discharge from MAU, your role in the process, your experience of your role, facilitators and barriers to successful discharge, to what extent current practice is successful.

The focus group will be recorded on a Dictaphone. You do not have to answer any questions that you do not want to and you can leave the focus group at any time. The data will be written up and analysed as part of the research. The write up of the focus group will be anonymous. You will be referred to by your profession (e.g. Nurse 1). If you are identifiable by your profession (ie. If there is only one Physiotherapist on MAU) you will be referred to more broadly (eg. Allied Health Professional). The information will only be used for this study.

ANONYMITY

All data will be anonymous and confidential. Study documentation and research data will be locked away at the University of Southampton for 10 years before being destroyed.

WHAT ARE THE BENEFITS OF TAKING PART?

The results of the study will help us to better understand the complex process of discharge decision making for older people in MAU. It will help to understand the facilitators and barriers for successful discharge decision making.

For your convenience a light lunch and drinks will be provided during the focus group.

ARE THERE DRAWBACKS TO TAKING PART?

The focus groups are expected to be straightforward and to cover territory that would be expected as part of your normal job role. In the unlikely event that something is heard that suggests unacceptable or unsafe practice, the focus group facilitator will be required to report this matter locally. He or she will discuss this with you and will explain what will happen. This is designed to safeguard patients.

We cannot guarantee that other focus groups participants will not report what you say outside of the focus group to others. We will however encourage people taking part in focus groups to verbally agree to ground rules of confidentiality.

You have the right to withdraw from the study at any time and this will not affect your rights or your role at work.

WHAT HAPPENS TO THE RESULTS?

You have the opportunity to receive the final report of the research findings if you would like. The study report will be submitted as part of the researcher’s PhD papers. The researcher may also present the findings at conferences or publish them in academic journals.

CONTACTS

If you have a concern or complaint about this study, do not hesitate to contact:

Research Governance Manager	
Research Governance Office Building 37 University of Southampton Highfield Campus Southampton SO17 1BJ	02380 595058 rgoinfo@soton.ac.uk

If you would like more information you can contact the researcher direct:

Appendices

Annabel Rule – email: ar17g09@soton.ac.uk phone: 07845408002

Thank you for your time

Appendix N Hospital staff consent form

CONSENT FORM – Hospital Staff

Title of Project: The Process of discharge decision making for older people returning to the community from a general hospital short stay unit – a case study

Name of Researcher: **Annabel Rule**

Please initial the boxes if you agree with each section

1. I confirm that I have read and understand the information sheet dated **2/07/2014** (version 5) for the above study.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without me, my work or legal rights being affected.

3. I agree that a tape recording will be made. I understand that this recording will be heard by no one else, that it will be labelled so that I cannot be identified, and that it will be destroyed when the research is complete.

4. I understand that confidentiality cannot be guaranteed for information which I might disclose in a focus group.

5. I agree to take part in the above study.

6. I would like a summary of the findings when the research has been completed: Yes/No (please circle)

If you would like a copy of the findings, please write your address/email address clearly here:

Name of Participant

Signature

Date

Name of Person taking consent

Signature

Date

Appendix O Demographic details form

Demographic Details Form

REC reference number: 14/YH/1102

Name:	
Job Title:	

Please complete this form to the best of your ability.

Appendices

Amount of time working on the AMU (Approximately):	
Years worked since qualification:	
Highest Qualification: (e.g. MSc, BN, PGDiploma, Diploma, BSc etc.)	

Appendix P Junior doctors topic guide

Introduction to the project and the participant information sheet

Gaining consent

- Can you talk through the process by which the decision is made for an older person to go home?
- How is that decision made?
- What other decisions need to be made around discharge?
- What is your specific role in making that decision?
- How does the older person come to learn of that decision?
- What do the older people do to contribute to the making of that decision?
- What expectations does the Trust have for discharge decision-making?
- To what extent do these expectations impact your practice?
- How do patient's relatives feature on the decision making process?
- What do you understand to be older people's experiences of how the decision is made for them to be discharged?
- Do you think current practice of making decisions for discharge for older people could be improved? If so how?

Appendix Q Nurses' topic guide

Topic Guide - Nursing Team

1. What is the process of discharge decision making for older people on the AMU?
 - a. Is the process of discharge decision making for older people different to younger people?
2. How is the decision to discharge an older patient made?
3. What is the nursing role in discharge decision making?
 - a. How are discharge decisions communicated with patients?
4. What kind of expectations does the trust have for patients' discharges?

(Examples to prompt discussion; bed meetings, trust status, bed managers, emails)

 - a. Does the organisation have targets to meet or any other pressures?
 - i. How are these targets/pressures communicated? How do you know about these?
 - b. To what extent do these pressures impact you and how decisions are made?
 - c. To what extent does bed management factor in to discharge decisions?
5. When is discharge planning commenced?
 - a. Is it possible to predict an older person's length of stay or amount of support on discharge they may need? If, so when can this be predicted?
6. What are the roles of patients and relatives in making the decision to go home?
 - a. To what extent are patients and relatives involved in decision making?
7. How do you know when a patient is ready to go home?
 - a. What do the nursing team do to help prepare patients to manage at home?
 - b. What do the nursing team do to ensure a patient is ready to go home?
8. What do you think is the patient experience of discharge decision making on the AMU?
9. How could discharge decision making be improved on the AMU?

Appendix S Coding Summary

PARENT CODES	DESCRIPTION/EXPLANATION	NOTES ON FREQUENCY AND IMPORTANCE
ALL OF A SUDDEN	Description related to how the plans or the discharge came about. Referring to things happening quickly and without warning.	Mentioned by junior doctors but mostly in patient experience. Important as it is the norm. It is the way it feels. It's the way decisions are made. Decisions go from not being made, after one consultation or discussion to being made. Once the decision is made things move quickly.
ASSESSMENT DRIVEN DECISION	Instances where it has felt that the decision to be discharged is hinged on the outcome of one assessment or one test. It tends to be a checking that something is OK. If it is then the discharge continues or is initiated. May include reference to having to wait for a test in order to go home.	Reference to this in field notes from phase 1, patient reports, extracts of patients' notes and junior doctors' interview. It is an example of when things are more simple and predictable. When patients, family and HCPs know that the outcome of whatever test will dictate a going home or not. A rare example of when things ARE cut and dry in the process.
ASSUMPTIONS ABOUT FAMILY SUPPORT ON DISCHARGE	Makes reference to times when knowledge or expectations of or about patient's family has just been assumed to be true by the HCPs. It hasn't been checked explicitly or the family feel they were never explicitly asked. Usually relates to level of care or support they are going to provide, but also whether or not they are physically fit or able themselves. References potential care strain that was being experienced before that has not been properly addressed.	This is an important code. It's potentially a broader theme as it is a thematic category for 9 smaller codes. These codes are frequently and consistently referenced across all sources of data.
CATEGORISING PATIENTS:	Evidence of patients being categorised by an aspect of their care, symptoms or presentation. A judgement is made according to how that patient has been viewed by health professionals. Includes the dichotomy of mobile and non-mobile, categorisation by illness, referring to	Very important code. Displays the various judgements and categorisations by HCPs. They do this frequently in field notes to understand the patients' care and the trajectory of their stay.

<p>ALSO INCLUDES SUB-CODE;</p> <p>BLESS THEM</p>	<p>patients by their bed numbers or the length of their stay, judgements that patients are 'sensible', 'usual' or straightforward. Reference also made to staff disapproval of patient actions or statements.</p> <p>Staff make reference to patients in a positive, caring way that could also be interpreted as patronising and not necessarily age appropriate. Categorisation of patient as 'sweet' for example.</p>	<p>Mentioned in field notes and nursing perspectives. Similar to previous research 'Poppets' (Maben et al.)</p>
<p>COMMUNICATING THE DECISION</p>	<p>Collective title for codes relating to how and when the communication between HCP and patient or HCP and relative actually occurs in reference to discharge.</p> <p>Incorporates codes regarding communication behaviours such as explaining and giving information as well as reflections on the good and (mostly) bad communication that occurs.</p>	<p>Integral code in order to break down how the discharge decision is actually communicated. Needs to be understood within the context of the unit though. Does not make sense stood alone or separate.</p>
<p>COMPLIMENTS ON CARE FORM PATIENTS AND FAMILIES</p>	<p>When a compliment was made about an individual encounter or person right through to the idea of the NHS as a whole.</p>	<p>Solely perspectives of patients and relatives.</p> <p>Important as sets their less comfortable experiences within the context that they were generally quite pleased with their care.</p> <p>Very frequently references (N=25)</p>
<p>CONCERNS ABOUT CARE</p>	<p>All concerns expressed about care or where basic care has been missed.</p> <p>From reports of patients, relatives, health professionals and field notes.</p> <p>Not specific to discharge but more general.</p>	<p>Important for setting the scene about the priorities of the organisation and the difficulty to meet some of the more basic needs within this environment.</p>

<p>CONFUSING CARE FOR PATIENTS AND RELATIVES</p>	<p>Experiences where care, discharge and the environment were confusing or uncertain for patients or relatives. Includes codes on disorientation and unclear identities of different health professionals as well as unclear plans and confusion.</p>	<p>Notable frequency. Experience is part of the norm</p>
<p>CORRECT PROCEDURES</p>	<p>Times when the 'correct procedures' seemed to take place. Mostly around no delay and seamlessness</p>	<p>Negative case to the more frequent experiences where care wasn't as seamless or 'correct procedures' weren't experienced.</p>
<p>DESCRIPTION OF THE UNIT</p>	<p>Code encompassing any moment of description in the data. Factual descriptions about the layout and some of the norms of the unit i.e. visiting times, alert systems, GP queue etc.</p>	<p>Integral code in setting the scene of the unit and adding to the context in which discharge decisions are being made</p>
<p>DISCHARGE PLAN TO SUIT INDIVIDUAL NEEDS AND PREFERENCES</p>	<p>When there is evidence that the plans and discharge have been tailored to or explicitly considered the needs or preferences of the patient, their family or their general social situation.</p>	<p>This is important as a negative case to the other experiences of pace focus. Arguably these experiences are positive although arguably tokenistic. Interestingly, all references under this code are from patients' own accounts, rather than in the field fieldnotes.</p>
<p>DISJOINTED PROCESSES</p>	<p>Description of processes and systems in the hospital that staff are working within that are disjointed and/or difficult to negotiate or understand. Includes when things have appeared arduous, disorganised and interrupted.</p>	<p>Most frequent code (references N=26) Very important. Sets out the norms of working in this environment</p>
<p>ENVIRONMENT NOT FIT FOR PURPOSE</p>	<p>References to when staff or patients have found it difficult to complete tasks within the environment. Office spaces, ward spaces etc. This code is about the physical space in which the work occurs.</p>	<p>Links to code above. Found in staff perspectives and field notes. Adds to the understanding of the norms in which discharge decisions are made as well as to why hospital staff are disillusioned and not feeling professionally satisfied</p>
<p>FAMILY TOOK OVER</p>	<p>Reference made to when a patient's relatives took over the organisation, arranging and sometimes the communication with HCPs about a patient's discharge plans.</p>	<p>This is fairly frequent and does show the advantageous position of those who have proactive family. It doesn't feel particularly novel but it is important to acknowledge</p>

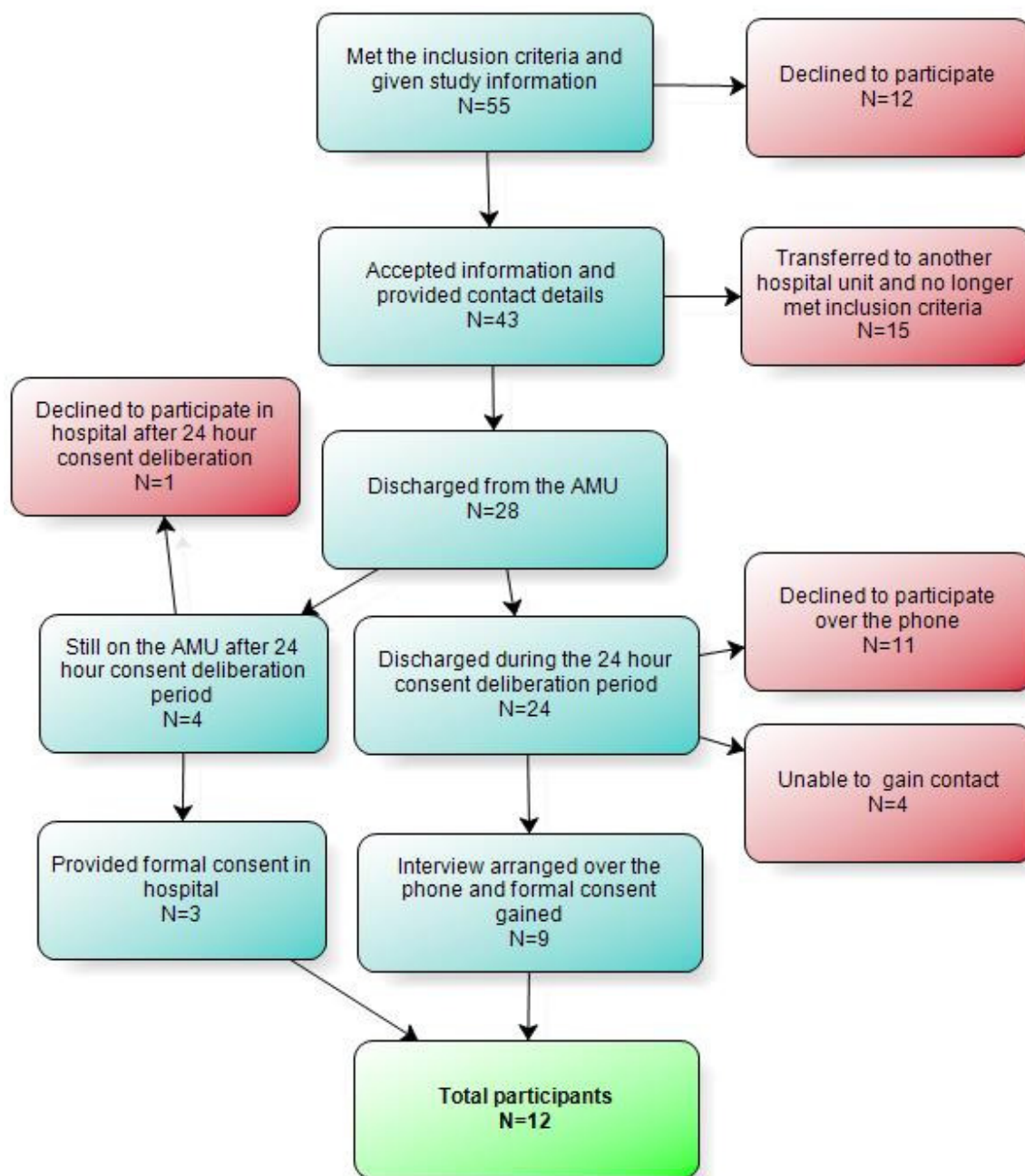
<p>FOR DISCHARGE, HCPS CONSIDER;</p>	<p>A code that encompasses all of the things that HCPs consider when making a decision on discharge. Includes; capacity, confidence, follow up care, mobility, functional ability, mental health, multimorbidities, social input, pain, safeguarding, patients own opinions and the time of day of discharge.</p>	<p>This is an important code for explaining what is going on in HCPs minds when making decisions and really shows the wide array of aspects of how a patient is presenting or feeling that needs to be considered. A code for detailing the complexity.</p>
<p>GOD FORBID WHAT IT'S LIKE FOR PEOPLE WORSE OFF</p>	<p>Patient perspective. Wondering out loud that their discharge experience would have been much worse if they had been in a different position. Largely if they were more poorly, less mobile, less alert or if they didn't have family.</p>	<p>This highlights the self-aware patient. Knowing they have got it ok, observing what is difficult or problematic in the system and reflecting on where it could go wrong for people worse off.</p> <p>Reinforces idea of patients effacing themselves.</p>
<p>HCP AUTHORITATIVE VOICE</p>	<p>Instances where the health professional had the authoritative voice in decision making. They made the decision. They spoke about it with the patient in a tone or using a phrase the reinforced their authority in the environment.</p>	<p>This is very frequently referenced across all sources and times.</p> <p>Important as arguably evidence of the overriding paternalism that still exists. (When compared to the volume of coding in the code representing person-centred care.)</p>
<p>HCPS DISAGREEING</p>	<p>Reference made to HCPs disagreeing either to each other or through the patient</p>	<p>Further evidence that the decision making process is not clear cut for HCPs either.</p>
<p>HELPFUL RELATIVES</p>	<p>All of the ways in which family members are considered helpful or have been helpful either to the patient or to the staff.</p>	<p>Very important in view of relatives as facilitators to the process. Links to family took over, god forbid what it... and when relatives are not facilitators.</p>
<p>HOSPITAL DIDN'T ALLOW INDEPENDENCE</p>	<p>Evidence of when the hospital or the staff working within it did not encourage or even allow for patients to exercise some independence.</p> <p>Examples include not having a mobility aid nearby and needing to call the nurse to move or wearing pads instead of going to the toilet</p>	<p>Features as part of hospital norms. Promoting independence is not at the forefront of priorities for health professionals as surrounding these people who may be able to do for themselves are very ill people for whom getting out of bed would not be an option.</p>
<p>OLDER PEOPLE ARE DIFFERENT TO OTHER PATIENTS</p>	<p>This code sets out the intricacies and differences in older people's care as opposed to general care for all ages on the AMU</p>	<p>It helps to discern why the focus on older people's care is of most importance.</p>
<p>ORGANISATIONAL</p>	<p>This code sets out some of the</p>	<p>Very important. Links most closely</p>

BARRIERS TO DELIBERATE	<p>barriers that have to be negotiated by hospital staff.</p> <p>It is more than description of the unit and also differs to behaviours of staff. Includes the 'everyday battles'</p>	<p>to disjointed processes. Could encompass disjointed processes but is also different as it speaks of things that are more prescribed by the organisation than poorly organised</p>
PACE	<p>Evidence where the pace of the organisation have been the focus. Reference to patients needing to leave and the need for bed.</p>	<p>Mainly reports from patients referencing the need for beds. This code could begin to umbrella other codes eventually.</p>
PATIENT APPROACH TO DISCHARGE DECISION-MAKING	<p>Encompasses what patients are thinking or feeling or seen to be thinking or feeling with regard to their discharge. Includes taking control, being worried, negotiating etc. Behaviours as well as attitudes or perspectives.</p>	<p>Important alongside HCP approach.</p> <p>Very large parent code with lots of small codes within it.</p>
PATIENT FEELS GUILT	<p>Reference made by patient of feeling guilt or burden by being a patient. Includes how they view staff in guilt inducing way.</p>	<p>Very important. Helps to understand the self-effacing notion again.</p>
PATIENTS ON THE CONVEYOR BELT	<p>Reference made to being a patient comparable to being a processed rather than cared for. Conveyor belt is verbatim code but also includes other language indicative of being transported as an item rather than a person.</p>	<p>Very important.</p> <p>Shows how impersonal the care can feel or seem</p>
RISK	<p>Reference to the ways in which the risk associated with discharge is assessed for, processed and accounted for. Includes responsibility for risk. Mainly in the eyes of the staff.</p>	<p>Very important as risk plays big factor in health professionals general practice let alone in discharge. Could be linked to what HCPs consider but probably is stand alone.</p>
STAFF BEHAVIOURS IN DISCHARGE PLANNING	<p>Reference to the behaviours exhibited by staff in discharge decision-making. Includes advocating, negotiating and worrying.</p>	<p>Very important in understanding the characteristics of discharge decisions and the variance between how staff behave and how patients behave.</p>
TEAMS	<p>Organisational code used to identify the norms, behaviours and practices of the individual teams. Pharmacy, physiotherapist, CEDT, nurses, junior doctors and consultants.</p>	<p>Not necessarily for inclusion in main themes but helps as reference point for researcher.</p>
THE RESEARCHER	<p>Organisational code identifying areas where the researcher may have had an impact on what was occurring or elements of reflection</p>	<p>Helpful for writing the methodology of thesis not necessarily for findings</p>

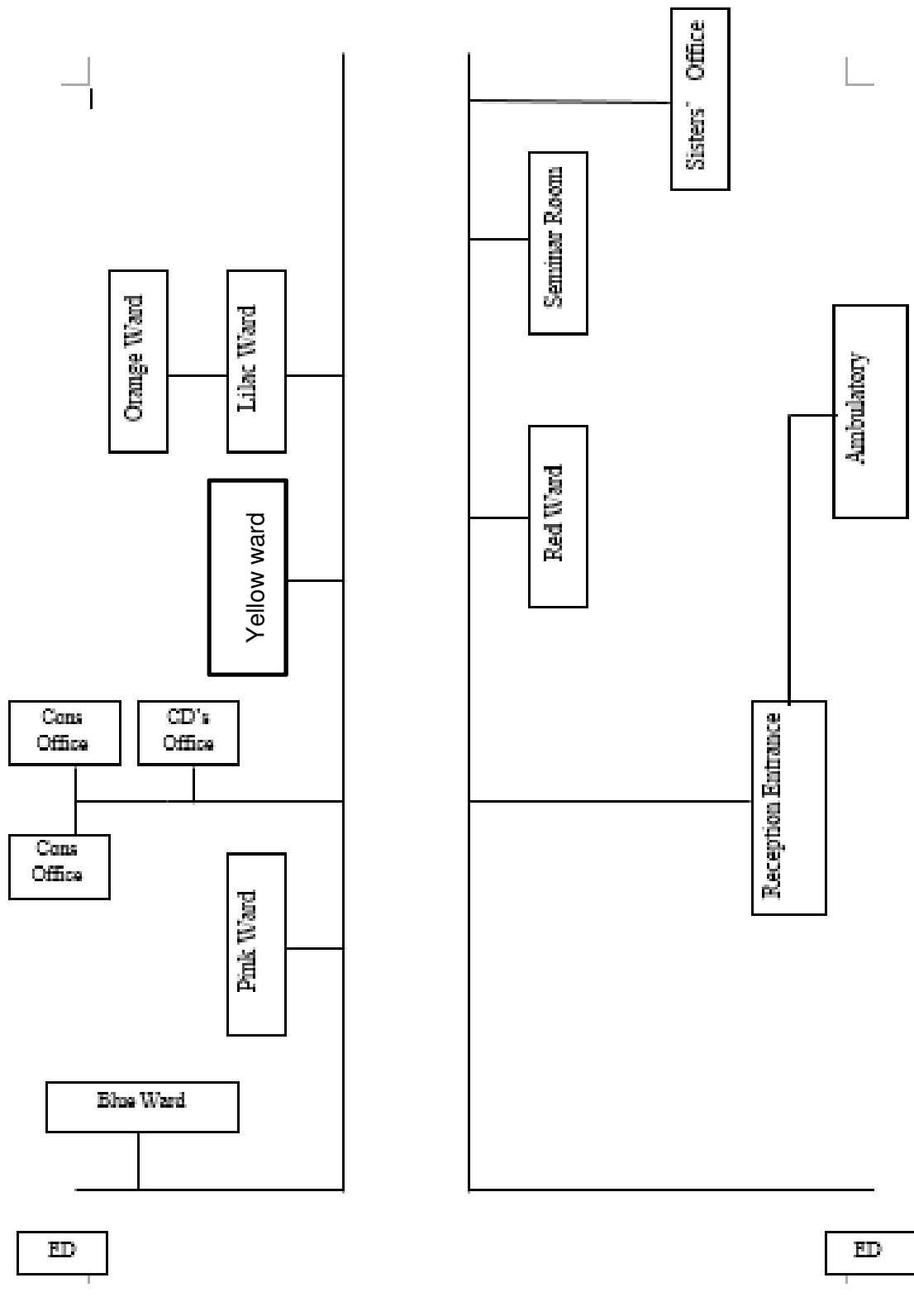
Appendices

THEY WEREN'T RUSHING US	Reference by patient to feeling of not being rushed or feeling like they were given adequate time by the staff and the hospital	Negative case for pace focus. Important to think about why the patient would tell me they weren't rushing us. As though that defied expectation
WHEN RELATIVES ARE NOT FACILITATORS	Instances where family members have not been seen as a facilitator but rather a barrier.	Negative case to helpful relatives.

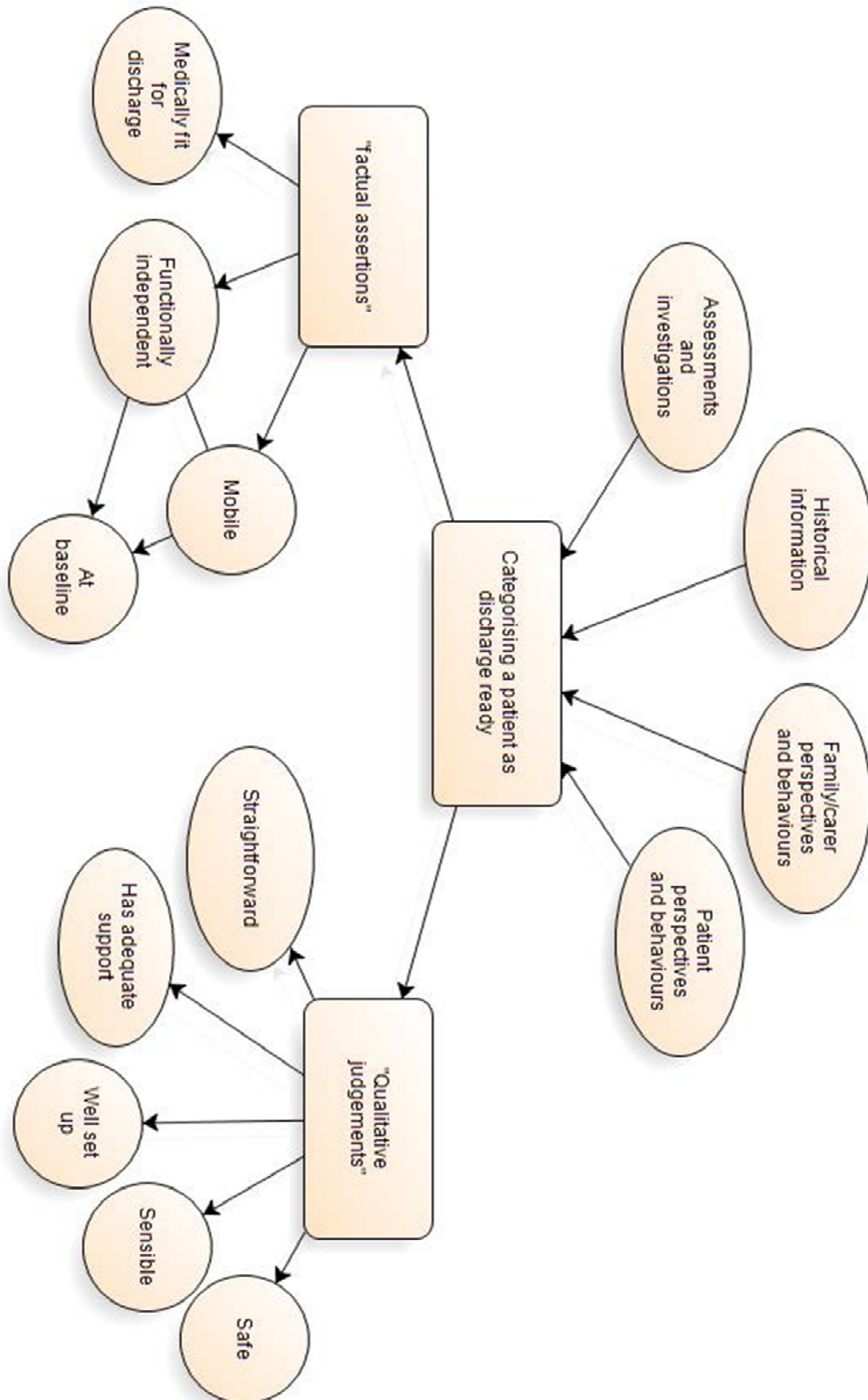
Appendix T Recruitment flow chart for patient participants



Appendix U Map of the AMU



Appendix V A model of categorising patients as discharge ready



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