

**A MULTIPLE CASE STUDY OF PATIENT
JOURNEYS IN WALES FROM A & E TO A
HOSPITAL WARD OR TO HOME WITH
THE SUPPORT OF THE EARLY
RESPONSE SERVICE.**

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“I may not be able to produce something round, but have produced something square to leave in this world”,
Sera Nia Manning, 2014.

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ABSTRACT

OBJECTIVE - This research discovers patients' experiences of the new and traditional routes of care and reveals the advantages and disadvantages of each within a chosen locality. It informs how a community service is delivering the new health agenda and most importantly how the patients feel and perceive their journeys through community-based care and hospital-based care. Therefore, its findings are crucial as feedback on how successful health plans have been to move more care to the community. It will reveal the Early Response team's processes to ensure the service is fully utilised in intermediate care and give a better understanding about which patients are suitable for the home service.

DESIGN – This qualitative research takes the form of multiple case studies encompassing semi-structured interviews to encourage discussion on the topic of care journeys. Participant information sheets and consent forms were used. The anonymity of the participant was upheld by using a pseudonym to refer to their contribution. All patients gave consent for the staff member who assessed them to be interviewed giving a total of three case study sources of the home patient, the hospital patient and the staff member as the units of measurement. Themes were searched for in the coding process derived from Kolcaba's (2010) comfort theory and the bio-psycho-social model (Engel, 1977). These were physical, psychological, social and environmental along with two themes derived from the literature review of age discrimination and loneliness. Data generated helped ascertain the success of an alternative type of care service and formulated recommendations for practice.

SETTING - The patient interviews took place at the patients' home so that they had time to experience their care pathway. Staff interviews took place in a quiet room at their place of work. Flexibility was offered regarding location, time of day and if the patients wished relatives to be present.

PARTICIPANTS - 10 patients and 10 staff were interviewed totalling 20 participant interviews. The patient group was split into 5 patients who attended A & E and received their subsequent care in hospital and 5 patients who attended A & E and

were able to receive their subsequent care at home with the Early Response Service. The patients from each group were matched on the basis of same/similar injury. Each staff member who assessed the patients was matched to their patient, giving a multiple case study of the home and hospital patient and two staff members. The age range of patient participants was 72-89 years old and the staff participants 39-58 years old. There were 8 females and 2 males in the patient group and 9 females and 1 male in the staff group.

RESULTS – Data were analysed using the six theme headings and by searching through data for specific reference to answering the research questions. Key words found were burden, coping, independence or dependence, recovery, pain, equipment, finance, frailty and disorientation. Comfort took the form of pain relief, carer assistance and reassurance, not feeling a burden and having needs met in a timely fashion. Discomfort took the form of pain, cold, hunger, loneliness, finances, disorientation and needing more flexibility in carer calls. Tabular analysis revealed all hospital admissions were necessary and the reasons for admission were more serious or required medical/surgical intervention compared to the home care group. Positive home patient comments included being able to have care at home with less disruption to patients' social networks and positive hospital patient comments included being able to receive maximum assistance over a 24 hour period as they felt they could not have coped at home. Results in relation to ageing theory, age discrimination and loneliness are discussed and interestingly care at home can be interpreted as positive discrimination of the older person by offering an alternative care option. Both hospital and home patients were satisfied with the care they received on the whole.

CONCLUSION – The Early Response Service are correctly identifying the most suitable patients to receive care at home. An improvement in staff resources or skills such as intravenous drug administration would widen their referral criteria to be able to offer their service to more patients. There is still work to be done in respect of pulling patients out of hospital who are deemed medically stable, but are waiting for social care packages.

CONTENTS

CHAPTER 1- Introduction to the Study	p10
1.1 Background to the Research.....	p11
1.1.1 Research Objectives.....	p14
1.1.2 Historical Background.....	p16
1.1.3 Policy Background.....	p21
1.2 Research Problem/Question.....	p34
1.3 Justification for the Study.....	p35
1.4 Methodology.....	p38
1.5 Outline of the Thesis.....	p39
1.6 Conclusion.....	p40
CHAPTER 2 – Concept Analysis of Intermediate Care	p41
2.1 Introduction.....	p42
2.1.1 Concept Analysis of ‘Intermediate Care’.....	p43
2.2 The Early Response Service within Intermediate Care.....	p55
2.3 Conclusion.....	p58
CHAPTER 3 – Theoretical Assumptions	p59
3.1 Introduction.....	p60
3.2 Theoretical Framework.....	p60
3.3 Conclusion.....	p66
CHAPTER 4 – Literature Review	p68
4.1 Introduction to the Review.....	p69
4.2 Related Disciplines.....	p70
4.2.1 Age Discrimination.....	p71
4.2.2 Loneliness.....	p76
4.3 Immediate Discipline.....	p82
4.3.1 General Literature Search.....	p83

4.3.2 Specific Literature Search.....	p84
4.4 Summary.....	p95
4.5 Conclusion.....	p98
CHAPTER 5 – Methodology.....	p100
5.1 Introduction.....	p101
5.2 Case Study Methodology.....	p102
5.3 The Use of Case Study Approach in This Thesis.....	p105
5.4 Data Collection and Analysis Procedures.....	p111
5.4.1 Data Collection.....	p111
5.4.2 Data Analysis.....	p120
5.5 Ethics.....	p123
5.6 Validity.....	p127
5.7 Conclusion.....	p130
CHAPTER 6 – I: Data Analysis II: Study Results.....	p133
6. Introduction to Chapter.....	p134
6. Part I: Analysis of Data.....	p136
6.1 Introduction.....	p136
6.2 Sample Population.....	p136
6.3 Thematic Analysis.....	p138
6. Part II: Results.....	p142
6.4 Multiple Case Study Results.....	p142
6.5 Summary of Theme Findings.....	p171
6.5.1 Physical.....	p171
6.5.2 Psychological.....	p172
6.5.3 Social.....	p173
6.5.4 Environmental.....	p174
6.5.5 Age Discrimination.....	p175
6.5.6 Attainment of Holistic Comfort through Relief, Ease and Discomfort.....	p176
6.6 Conclusion.....	p178

CHAPTER 7 – Study Results in Relation to the Researcher’s Mental

Framework	p180
7.1 Introduction.....	p181
7.2 Discussion on New Themes that have emerged from Data.....	p182
7.3 Results in Relation to the Research Questions or Mental Framework.....	p184
7.3.1 The Success of Providing Alternative Care at Home.....	p184
7.3.2 How Each Pathway Addressed the Four Elements of Holism.....	p186
7.3.3 Suitability of Each Patient to the Two Pathways.....	p187
7.3.4 The Criteria of Early Response Help at Home.....	p189
7.3.5 Patients’ positive and Negative Experiences on Care Pathways.....	p190
7.3.6 Age Discrimination and Loneliness.....	p194
7.3.7 Resources Needed to Care for People at Home.....	p197
7.3.8 Environmental Issues.....	p198
7.3.9 The Multi-Disciplinary Team and Family Input.....	p198
7.3.10 Delayed Discharges.....	p200
7.3.11 Readmissions and Reaching Independence.....	p200
7.4 A Summary of the Findings in Relation to the Research Questions.....	p201
7.5 Conclusion.....	p204

CHAPTER 8 – Conclusions & Discussions.....

8.1 Introduction.....	p208
8.2 Conclusions about the Research Question.....	p209
8.3 Conclusions about the Research Problem.....	p212
8.3.1 Type of Professionals.....	p213
8.3.2 Doctors’ Input.....	p213
8.3.3 Partnership Working.....	p214
8.3.4 Transitional Care.....	p215
8.3.5 Health Outcomes.....	p216
8.3.6 Professional satisfaction.....	p217
8.3.7 Future of Intermediate Care.....	p218
8.4 Implications for Practice.....	p218
8.4.1 Participants’ Recommendations for Practice.....	p221
8.5 Implications for Policy.....	p227

8.6 Validity and Limitations to the Study.....	p229
8.7 Further Research.....	p233
8.8 Dissemination of Findings.....	p236

DIAGRAMS

DIAGRAM 1 – NHS System of Care Delivery.....	p33
DIAGRAM 2 – Egan’s Bio-Psycho-Social Model (1977).....	p61
DIAGRAM 3 – Example of a Unit of Four Cases.....	p121
DIAGRAM 4 – Summary of NHS System Effects of Intermediate Care.....	p219

TABLES

TABLE 1 – Local Health Board Policies.....	pp12-13
TABLE 2 – Chronological NHS Reforms.....	pp21-23
TABLE 3 – Avant & Walker’s 8 steps of Concept Analysis.....	p43
TABLE 4 – Total Articles Found.....	p70
TABLE 5 – Summary of a Search Process.....	p85
TABLE 6 – Matched Injuries.....	p137
TABLE 7 – Core Categories.....	p139
UNIT OF ANALYSIS 1.....	p142
TABLE 8 – Mrs Atkins’ Comfort Needs Met.....	p145
TABLE 9 – Mrs Alderson’s Comfort Needs Met.....	p148
UNIT OF ANALYSIS 2.....	p149
TABLE 10 – Mrs Brown’s Comfort Needs Met.....	pp150-151
TABLE 11 – Mrs Biggins’ Comfort Needs Met.....	p153
UNIT OF ANALYSIS 3.....	pp153-154
TABLE 12 – Mr Cavell’s Comfort Needs Met.....	p156
TABLE 13 – Mrs Crawford’s Comfort Needs Met.....	pp157-158
UNIT OF ANALYSIS 4.....	p158
TABLE 14 – Mrs Doyle’s Comfort Needs Being Met.....	pp161-162
TABLE 15 – Mrs Dudley’s Comfort Needs Being Met.....	p164
UNIT OF ANALYSIS 5.....	p165
TABLE 16 – Mrs Elton’s Comfort Needs Met.....	p168
TABLE 17 – Mr Evesham’s Comfort Needs Met.....	pp170-171
TABLE 18 – Hospital Admissions Necessary.....	pp187-188

TABLE 19 – Reasons for Admission.....	pp188-189
TABLE 20 – Patients Satisfaction with their Care.....	p190
TABLE 21 – Positive & Negative Comments about Care Received.....	pp191-193
TABLE 22 – Results in Relation to Ageing Theory.....	pp195-196

REFERENCES.....	pp237-253
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APPENDICES

APPENDIX 1 – Intermediate Care Criteria.....	p254
APPENDIX 2 – Favourable Ethical Opinion.....	p256
APPENDIX 3 – Staff Interview Schedule.....	p260
APPENDIX 4 – Patient Interview Schedule.....	p262
APPENDIX 5 – Staff Information Sheet.....	p264
APPENDIX 6 – Patient Information Sheet.....	p269
APPENDIX 7 – Staff Consent Form.....	p274
APPENDIX 8 – Patient Consent Form.....	p276

CHAPTER 1

INTRODUCTION TO THE STUDY

1. INTRODUCTION TO THE STUDY

1.1 Background to the Research

This study focuses on the area of intermediate care and analyses patient journeys through two different care pathways. The purpose of the analysis is to examine new and traditional routes of care and explore their differences from both the patients' and nurses' perspectives. The distinct difference in these two pathways is that one patient group will be experiencing care in hospital and the other group will experience care at home with the new **Early Response Service (ERS)** which is part of intermediate care. An example of this is where a patient falls and suffers a broken bone so cannot undertake their daily activities. Traditionally they would be cared for at hospital, but now they can be cared for at home with intermediate care services. It is interesting to examine what types of patients can be cared for at home and what differentiates them from patients needing care in hospital.

The main research question is:

How do two different types of health service provision, traditional and new, compare in meeting patients' needs according to patient and staff experiences? By gaining data on this question in the form of interviews with patients and staff members, comparisons between the services, their advantages and disadvantages are able to be drawn. This facilitates an analysis on the effectiveness of a new type of care at home service as advocated in both local and national health policy (WAG, 2005; DH, 2001). Criteria which determines the success of each service includes cost, recovery rate, patient satisfaction, physical, psychological, social and environmental well-being. There is also an exploration of the themes of age discrimination and loneliness under the social and psychological data analysis headings to ascertain comparable data between hospital and home experiences.

An important group to give the opportunity to be heard is that of staff members' experiences of each of these care pathways. It is interesting to gain both patients' and staff members' experiences in a qualitative study of a health service delivery change. Health service changes have arisen due to findings from reports such as the 'Wanless Report' (DH, 2002) which has hastened a new era in healthcare to plan

services for the future to an increasingly older population putting extra demand on services.

A shift in thinking in the way care is delivered has been needed, aiming towards a whole-system approach of health and social services ('Setting the Direction', WAG, 2010). This has taken the form of devolving care to the community, where people who need it can easily access it, while hospitals move to a centralisation of specialist, acute and critical care services. For certain localities this has meant an 'invest to save' ethos with new district general hospitals being built and older ones closing (WAG, 2010). The emphasis is for better utilisation of hospital beds, a seamless service with community health providers and partnership working with social services. Hence, it is a more efficient way to deliver targeted healthcare and initiatives have been implemented across Britain with particular importance placed on the development of intermediate care.

All documentation and references that can identify the chosen research locality, its local health board and comparable local health boards have been removed. Pseudonyms have been used instead such as 'First Local Health Board', 'Second Local Health' and 'Anytown' or 'Newtown'. These pseudonyms will be presented in inverted commas or in brackets when referenced throughout this thesis. To reference the Local Health Board source would expose their locality, therefore the below table has been constructed for the reader without the name of the locality.

TABLE 1 – LOCAL HEALTH BOARD POLICIES

LOCAL HEALTH BOARD	YEAR	POLICY
First Local Health Board & 'Anytown' Trust	2006	Better Health Services for 'Anytown': Consulting on the Future Shape of Local Health Care
First Local Health Board	2010	Changing for the Better Our Five Year Plan: Quality Service, Workforce & Financial Framework 2010-15
First Local Health Board	2011	Website (intermediate care team information)
Second Local Health Board	2009	Happily Independent. The Strategic Vision for the 'Newtown' Frailty Programme
Second Local Health Board	2011	'Newtown' Frailty Programme

Third Local Health Board	2011	Website (intermediate care team information)
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In the chosen research locality a large healthcare organisation in Wales produced their own document, 'Better Health Services' (First Local Health Board & Anytown NHS Trust, 2006). This document explains the need to deliver care "in the right place, at the right time and by the right person" (p4). It explains that 40% of beds are occupied by people whose care would be more effectively delivered in the community. This document was a driver for change to ensure hospital beds are better utilised for those needing acute care and patients who have less acute needs are discharged and supported at home. 'Changing for the Better' (First Local Health Board, 2010) reinforces the plans for more care at home and discusses the proposals to set up community resource teams which include the Early Response Service.

In 2009 the Early Response Service became part of the intermediate care service delivery strategy in the research locality. Health Boards, under targets set by the Welsh Assembly and Central Government, needed to cut admission rates and length of hospital stays (WAG, 2005; DH, 2001). Therefore, national policies have influenced the restructuring in health service delivery at local levels.

Davies (2000) states that policies are borne out of a process of decision making that is essentially rational such as a cycle of goal setting, gathering information, analysis, formulating, implementing and evaluating. To deliver on the policy agenda the research locality like other areas has had to reshape care delivery to relieve pressures on hospital beds and shift more care to the community. For some patients care has changed in that they no longer go through what can be considered as the 'traditional' route of a hospital stay, but return home with health and social care support. Therefore, the Early Response team and staff in Accident and Emergency (A & E) are screening and assessing patients at point of admission to identify those whose care may be better suited to being delivered at home.

This research explores the patients' experiences of the new and traditional routes of care and discusses the advantages and disadvantages of each. It also reveals the

level of partnership working between health and social services as advocated in 'The NHS Plan' (DH, 2000c). It explains how a community service is delivering the new health agenda and, most importantly, how the patients themselves feel and perceive their journeys through community-based care and hospital-based care. Therefore, its findings are crucial as feedback on how successful these health plans have been. It also exposes the team's processes to ensure the service is fully utilised and gives a better understanding on what patients are suitable for the service.

1.1.1 Research Objectives

Research Title

A multiple case study of patient journeys in Wales from A & E to a hospital ward or to home with the support of the Early Response Service.

Research Questions

- In light of health plans to shift more acute care to the community within the NHS care system (WAG, 2005), has the Early Response Service successfully achieved an alternative type of care available to patients in that they can be treated in their homes instead of hospital?
- What are the physical, psychological, social and environment problems this sample population experienced and how did each care pathway address these?
- Was the most appropriate type of patient treated in the most appropriate environment? Are any changes needed to the criteria of who receives care at home?
- To find out how the patients feel about their care? Did they have a positive experience on the chosen care pathway? Did the patients experience any age discrimination or loneliness?
- What resources are needed to enable caring for more people at home instead of hospital? Were there any environmental issues with receiving care at home?
- How effective are the multi-disciplinary team members in care delivery and are family involved in the patients' care?
- Are there any issues with delayed discharges to care at home services? Were there any re-admissions to hospital in the sample population or were patients able to reach independence at home?

Research Aims

- To discover the advantages and disadvantages of being cared for at home as opposed in hospital and vice versa.
- To discover what patient factors like type of injury and self-care ability determine the care pathway they follow.
- To discover the factors involved in length of recovery time and reaching independence, wellness and comfort such as the importance of multi-disciplinary team input.

Research Outcomes

- To have successfully achieved the patients' views on care received in the community and in a hospital. Positive experiences will portray the success of care received. Any negative comments are to be used as recommendations for practice to improve care systems.
- To have gained an understanding why ten patients with the same injuries took different paths of care. This will give enlightenment to the factors that determine whether a discharge can be facilitated or whether admission to hospital is appropriate. In turn this will help clarify the criteria of community care.
- Data collected will depict a holistic study including the patients' psychological, social, physical and environmental aspects of care. It is necessary to provoke empathy with the patients' journeys to better understand their experiences of systems of care from which professionals can learn.
- Themes from interviews will help construct a model of care excellence worthy of being benchmarked to other intermediate care teams who are also trying to prevent inappropriate admissions to hospitals.

It is necessary to first examine the historical policy background to the NHS and intermediate care. In chapter two a concept analysis of intermediate care will take place to gain a better understanding of this care remit and to look at how the Early Response Service came into being. This provides background information for the reader to understand the context of this research. Chapter four contains a literature review which will ascertain any other research in this area. The research process will

then be presented in subsequent chapters before findings and recommendations for practice are discussed.

1.1.2 Historical Background

Intermediate care exists today in the form of well-organised teams of professionals in the community who work to reduce inappropriate admissions to hospital and facilitate hospital discharge. According to Cowpe (2005) the major turning point to formally recognise this area of care came in the National Beds Inquiry (DH, 2000b) and the National Service Framework for Older People, Standard Three (DH, 2001). Cowpe (2005) states before this intermediate care only existed in small local initiatives to tackle local health problems with a small budget, therefore was fragmented in its delivery.

A form of intermediate care which existed before the 1990's was that pertaining to other patient groups. In the 1950's the Western industrialised countries moved to deinstitutionalise mentally ill patients into the community due to resource issues and newly available anti-psychotic drugs (Koyanagi, 2007). However, the necessary resources in the community to look after this patient group were scantily provided which resulted in lack of co-ordinated funding and access problems to education, employment, housing and healthcare (Koyanagi, 2007). Therefore, one could argue that this early attempt to move a patient group out of an institution into the community had the roots of intermediate care, but that the care provided in the community as an alternative was poorly organised to meet their needs (Koyanagi, 2007).

Nasrallah (2008) believes there were unintended consequences of this shift of deinstitutionalising mentally ill patients of crime, homelessness, imprisonment and social stigma. Fakhoury and Priebe (2007) have suggested that in recent times there is emerging an idea of re-institutionalising those mentally ill patients for whom community care has failed. This is an important lesson to be learnt for policy makers and health professionals; that any shift of healthcare into the community has to be adequately resourced and unintended consequences tackled otherwise a service change can fail some patient groups and result in poorer health care or readmission

to hospital. By the 1990's mental health community workers were becoming more organised in the form of crisis resolution, outreach and early intervention teams (Donaldson and Scally, 2009).

It is interesting to look at the origins of other labels of health care such as primary, secondary and tertiary as intermediate care is a more recent concept so exists due to failure of these service areas to meet all health needs. Even though primary care existed in the form of GPs and community nurses the label was not formally recognised until the Alma-Ata conference (WHO, 1978). The Primary Health Care model emerged from this conference due to work taking place in China and declared that health is a human right; health should be the primary goal with every government and involve community workers in the health system (Hernz, 2012). Primary care concerns everybody's health and is the first contact with health professionals in the community regarding symptoms of ill health (Torrey, 2011).

Secondary care is usually synonymous with hospital care or specialist health care. Secondary care was also already in existence in its form of hospitals for acute and emergency care and where specialists could be accessed, but it was not until the National Health Service Act (1977) that the label was formalised (Torrey, 2011). This helped it differentiate from primary care and this restructuring also helped with costing services. Tertiary care is defined as that needing highly specialised personnel and equipment and can be accessed through referral by secondary and primary care practitioners (Torrey, 2011). An example of this is cancer services where hospices and specialist cancer centres grew in the 1960's (Higginson, 1998).

Therefore, if these areas of healthcare were solidified sections of the National Health Service by the 1970's it brings into question why intermediate care has grown and unified to provide additional or alternative care? There were great demands on the traditional sectors of health care with an increasing elderly population (DH, 2000b, DH, 2002) and some patients' needs could more appropriately be met at home with intermediate care rather than in hospital to lessen demands on finite resources (WAG, 2005).

It is necessary to look back at the history of health service provision. Kickbusch (2007) states before the industrial revolution the only healthcare was the charitable hospital for the poor and bedside medicine from a doctor for the rich. The Poor Law of 1601 and subsequent amendments in 1834 and 1929 (Donaldson and Scally, 2009) had provided a form of health care in workhouses with often unsanitary conditions. Social progress, justice and the right to health came about in the Declaration of Human Rights (1948). The government could no longer ignore sanitation issues, the need for vaccination programmes, and better living and working conditions.

Bauman (2000) says we are currently in a period of post-modernity where modernity was the industrial revolution. All these effects changed the way healthcare was perceived and delivered in society. It had a knock on effect for the professions and their work in a sheltered market. However, medicine had the power to eradicate disease with drugs and advancing technology (Kickbusch, 2007), so remained in a strong position.

In 1948 healthcare in Britain became organised into the National Health Service (NHS) delivered in hospitals and primary care centres (Ackers & Abbott, 1996). The principle of equity allowed the poor to access free healthcare, through general taxation by the government. According to Donaldson and Scally (2009) Aneurin Bevan's original vision for a completely free NHS did not last long with overspending on budgets and gradually charges for dentists, opticians and prescriptions were introduced. The 1942 Beveridge Report assumed that costs would lessen as the nation's health slowly improved, but it had not allowed for the massive backlog of unmet need or for technological advances such as joint replacements (Cannon, 2002). Also, those cured of infectious diseases would later succumb to a different condition which would place additional demands on the health service (Rivett, 2012).

Thane (2009) states in 1940 a group known as, Age Concern, started campaigning for improved care of older people due to their unmet needs in the community and those who were disabled. This led to the Disabled Person's Employment Act, 1944, and The National Assistance Act, 1946, replacing the poor law for means tested

benefits (Thane, 2009). Thane (2009) goes on to explain that the 1950's saw a rise in out-patient care replacing in-patient care especially for mental health patients where there were increasing costs and harmful effects of long-term institutionalisation.

The 1960's saw an addressing of issues of care for older people in the community and the lack of co-ordination between health and social services (Thane, 2009). However, Baggott (1998) believes until 1974 community health services were largely controlled by local authorities and central government faced difficulties in developing a national vision for fragmented local services. The 1970's saw various social services acts such as, The Local Authority Social Services Act, 1970, to establish a single unified social department to meets needs of the family, accommodation, domestic help, and recreational services (Thane, 2009). Problems existed of independent contractors like GPs, dentists, opticians not supporting particular government policy, also poor management and quality of care in some areas (Baggott, 1998). Therefore, it appears that the NHS (1948) initially met health needs, but that health and social needs were so high, other measures such as providing care in the community were gradually being recognised but remained fragmented.

During the twentieth century, economic and social changes had influenced the power professions hold. Hospitals had grown basing their organisational structures on fordist and post-fordist ideas where each worker contributes a small part to the whole process (Walby et al. 1994). In 1974 an administrative reorganisation occurred to attempt to coordinate public health into local health authorities (Donaldson and Scally, 2009). A new wave of management appeared in 1982 which impacted on the medical profession (Ackers & Abbott, 1996). The aim was to provide a clear line of accountability and there was a call for unity of occupations to produce high quality patient care (Ackers & Abbott, 1996). Medicine could no longer provide all the services the patient needed (Dahlgren et al. 2004).

According to Donaldson and Scally (2009) the 1980's saw a series of clashes between professions providing the health service and the new general managers. The traditional concept of professions was no longer valid and had to evolve into a

dynamic concept to meet the changing demands of post-modernity. Thane (2009) states that the 1980's saw the shift of institutional care to the community gather pace due to the government cutting public spending and turning its attention to private rather than public provision. This is supported by Baggott (1998) who says the 1980's saw the Thatcher government strengthen the gatekeeper function of primary care to restrict demands on secondary care services.

Cowpe (2005) believes the 1990's saw a decrease in acute hospital beds available, an increased elderly population being admitted to hospital and a reduction in residential home placements available. Thus, there was an ever increasing demand on health and social services with limited resources available, which again created an environment to seek alternative types of care provision. Cowpe (2005) explains that trusts and health boards were responding to local service pressures with initiatives of a rehabilitative nature. This is supported by Ham (2009) who says that the NHS by the 1990's was giving more priority to preventative ill health strategies like adopting healthy lifestyles of not smoking and being overweight, to attempt to reduce the burden of health care demands. In 1997 the Labour government abolished internal markets and began devolving health care responsibility to local level emphasising partnership working between health and social care in a whole systems approach (Donaldson and Scally, 2009).

It was a natural progression when the National Beds Inquiry (DH, 2000b) came about to look at providing a sustainable intermediate care service to relieve pressures on both primary and secondary care. In the National Service Framework for Older People, Standard Three (DH, 2001) it is stated that the government intend to expand intermediate care services with £900 million investment. According to Donaldson and Scally (2009) the NHS in its first year cost £10 per head and by 2008 this had risen to £1800 per head. Therefore, facing increasing costs and demands for health services the government has shifted the emphasis for some care delivery to take place at home instead of at hospital as it is more cost effective (WAG, 2010). This in turn tightens the criteria for entry into secondary care but leaves primary care entry available to all suffering ill health.

1.1.3 Policy Background

In order to understand further the history of intermediate care it is necessary to track back the policies which have contributed to its emergence. A full list of the policies that have led to NHS reform has been listed chronologically by the Socialist Health Association (2013) in the table below. Until Wales was granted devolution in 1998 (Gov.UK, 2013) all policies affecting the NHS made centrally in England would apply to Wales also.

TABLE 2 - CHRONOLOGICAL NHS REFORMS

YEAR	LEGISLATION AND DOCUMENTATION
2012	Health and Social Care Act 2012 NHS Mandate
2010	Equity and excellence: liberating the NHS
2009	NHS Constitution
2008	Our NHS Our Future
2007	Local Government and Public Involvement in Health Act; Mental Health Act
2006	Our Health, Our Care, Our Say; Supporting people with long term conditions to Self Care
2005	A Patient-led NHS; Healthcare reform in England, Update and next steps.
2004	NHS Improvement Plan.
2003	Building on the Best; Choice, Responsiveness and Equity in the NHS; Health and Social Care (Community Health and Standards) Act
2002	Wanless report: Securing Our Future Health: Taking a Long-Term View; National Health Service Reform and Health Care Professions Act Delivering the NHS Plan
2001	Bristol Royal Infirmary report ;Shifting the Balance of Power; Health and Social Care Act
2000	The NHS Plan
1999	Health Act; Saving Lives: Our Healthier Nation
1998*	Scotland Act; Government of Wales Act; Information for Health. An Information Strategy for the Modern NHS. 1998-2005; A First Class Service: Quality in the New NHS; Modernising Social Services
1997	The new NHS – Modern, Dependable; NHS (Primary Care) Act; National Health Service (Private Finance) Act ;Designed to Care; Renewing the National Health Service in Scotland
1996	Choice and opportunity; Health Service Commissioners (Amendment) Act; Community Care (Direct Payments) Act; The National Health Service: A Service with Ambitions ;Primary Care: Delivering the Future
1995	Health Authorities Act; A Policy Framework for Commissioning Cancer Services
1994	Developing NHS Purchasing and GP Fundholding: Towards a Primary Care Led NHS
1993	Calman report: Hospital doctors' training for the future:
1992	Tomlinson report on London hospitals

1991	Junior Doctors, the New Deal. Working Arrangements for Hospital Doctors and Dentists in Training
1990	National Health Service and Community Care Act Access to Health Records Act
1989	Children Act; Working for Patients: The Health Service Caring for the 1990's; Caring for People: Community Care in the Next Decade and Beyond
1988	Community Health Councils (Access to Information) Act; Health and Medicines Act; Access to Medical Reports Act
1987	Promoting better health;
1986	Cumberlege Report -Neighbourhood nursing Primary health care – an agenda for discussion; National Health Service (Amendment) Act; A National Strategic Framework for Information Management in the Hospital and Community Health Services
1985	Hospital Complaints Procedure Act
1983	Mental Health Act 1983; Griffiths Report – National Health Service general management
1980	Health Services Act; Care in the Community
1979	“Patients first”; Nurses, Midwives and Health Visitors Act; Royal Commission on the National Health Service
1978	Medical Act
1977	National Health Service Act ;The Way Forward
1976	Resource Allocation Working Party (RAWP); Health Services Act ;”Priorities for health and personal social services in England”
1975	“Better services for the mentally ill”;Nursing Homes Act; Separation of Private Practice from National Health Service Hospitals
1974	Glancy Report on security in NHS psychiatric hospitals; “Management arrangements for the reorganised NHS”; Democracy in the NHS
1973	NHS Reorganisation Act
1972	National Health Service (Scotland) Act; Chronically Sick and Disabled Persons (Scotland) Act; NHS Reorganisation White Paper; Briggs report on nursing
1971	“Better services for the mentally handicapped”
1970	Chronically Sick and Disabled Persons Act ; The Future Structure of the National Health Service
1969	Ely Hospital Report; Bonham-Carter Report – Functions of the District General Hospitals; Administrative Structure of the Health and Personal Social Services in Northern Ireland
1968	Seebohm Report on Social Services; First scandals in long stay hospitals Health Services and Public Health Act
1967	The Cogwheel Report – Organisation of Medical Work in Hospitals; National Health Service (Family Planning) Act
1966	Salmon report – nursing structure; National Health Service Act
1965	A Charter for Family Doctors
1963	Health and Welfare: The Development of Community Care; Nursing Homes Act
1962	Enoch Powell’s plan for the development of District General Hospitals
1961	Powell’s Water Tower speech Platt Report -Joint Working Party on the Medical Staffing Structure in the Hospital Service

1960	Mental Health (Scotland) Act; Professions Supplementary to Medicine Act
1959	Mental Health Act
1958	Optician Act
1957	Royal Commission on the Law Relating to Mental Illness and Mental Deficiency
1956	Guillebaud Report: Cost of the National Health Service; Jameson Report on Field of Work, Training and Recruitment of Health Visitors; Medical Act; Dentists Act
1954	Bradbeer report on internal administration of hospitals
1952	National Health Service Act
1951	National Health Service Act; Midwives Act
1950	Medical Act
1949	National Health Service (Amendment) Act; Nurses Act
1948	Children Act; National Assistance Act
1947	National Health Service (Scotland) Act
1946	National Health Service Act
1944	A National Health Service
1942	Beveridge Report -Social Insurance and Allied Services
1939	Cancer Act
1937	Maternity Services (Scotland) Act; Report of the Voluntary Hospitals Commission
1936	Public Health Act; Midwives Act; Cathcart Report
1930	Poor Law Act, Mental Treatment Act
1929	Local Government Act
1927	Poor Law (Consolidation) Act; Nursing Homes Registration Act
1926	Royal Commission on National Health Insurance
1924	National Health Insurance Act ; Royal Commission on Lunacy and Mental Disorder
1921	Public Health (Tuberculosis) Act
1920	Interim Report on the Future Provision of Medical and Allied Services; Blind Persons Act
1919	Ministry of Health Act; Scottish Board of Health Act
1918	National Health Insurance Act; Maternity and Child Welfare Act
1913	Highlands and Islands Medical Services Act; Public Health (Prevention and Treatment of Disease) Act, Mental Deficiency Act
1911	National Insurance Act
1890	Lunacy Act
1875	Public Health Act
1848	Public Health Act
1845	Poor Law (Scotland) Act, County Asylums Act, Lunacy Act
1808	County Asylums Act
1601	Poor Law
	<p>*Up until 1998 where Welsh devolution occurred, all Department of Health policies above apply to England and Wales unless otherwise stated. Table Source: Socialist Health Association (2013) Reform of the National Health Service Chronology, pp1-6. www.sochealth.co.uk/national-health-service/reform-of-the-national-health-service [Accessed 25/04/2013]</p>

Some policies have already been mentioned in the historical section. In addition to these Thane (2009) states, The Mental Health Act, 1959, to enable the mentally ill to live in the community, The National Assistance Act Amendment, 1962, to provide day centres and 10 years plans for people to stay in their homes for as long as possible, along with The Health Services and Public Health Act, 1968, which increased local authorities power to provide services and make home adaptations, all contributed to strengthening community care services. From the table above the 1970's policies saw NHS reform acts and The Chronically Sick and Disabled Persons Act, 1970. Therefore, reforms to health and social services were continuous through post-war decades to improve the quality of care that could be provided.

'The Black Report' (DH, 1980) represents an effort by the government to explain health inequalities. It gave rise to debate on explanations for poor health like class, the gap between the rich and poor, lifestyle factors, income, place, upbringing and lack of health promotion. This started the impetus for preventative and rehabilitative health policy approaches up to the 1990's (Ham, 2009). After 'The Black Report' (DH, 1980) Britain signed up to 'Health For All Programme' (World Health Organisation, 1985), to decrease inequalities in health by the year 2000. However, the Welsh Assembly Government in 2005 found that this objective had not been met, despite advances in healthcare and increased life expectancy, inequalities continued to grow. Also, that vulnerable, poor people did not have equitable access to healthcare.

'The Black Report' (DH, 1980) was followed by 'The Health Divide Report' (Health Education Council, 1988), which updated evidence on health inequalities and supported previous findings on health inequalities. Following this, another important document was published 'The Acheson Report' (DH, 1998b), to highlight areas for improvement and inform future health policy on health inequalities. According to Benzeval (2002), since the 1980's the government has had to respond to pressure to tackle health inequalities and various health policies have been produced for example, 'Reducing Health Inequalities: An Agenda for Action', (DH, 1999a). However, evidence from the 'Wanless Report' (DH, 2002) found Britain had fallen behind other countries in meeting health inequality targets.

The Review of Health and Social Care in Wales (WAG, 2003) found Wales' current position worse than in Britain as a whole, reflecting trends over the decades. Townsend et al. (1988) found North England similar to Wales, with a history of decline in traditional heavy industries of coal mining, lack of new employment and consequent high levels of unemployment. Townsend et al. (1988) state the link between deprivation, socio-economic position and health is very evident in these areas where unemployment is four times more and car and home ownership is three times less.

It is important to briefly discuss health inequalities as these have influenced the construction of health policy in Britain since the 1601 Poor Law came into being (Socialist Health Association, 2013). Townsend and Davidson (1992) believe there is confusion over statistical methods for studying health and exposing inequalities. They believe mortality rates can show a variation in age at death, but does not show whether social inequalities in death are changing too. Therefore, there are limitations to this measurement approach which ignores chronic diseases. Also morbidity rates can ignore congenital conditions. The authors advocate using an approach which captures all factors of real experiences of health; otherwise important data will be omitted.

According to the Welsh Assembly Government (2005) there is a legacy of a relationship between mortality rates and socio-economic inequalities, and level of deprivation of a locality and life expectancy. A person's social class and economic position has been central to the work of health inequalities (Townsend and Davidson, 1992). Class has traditionally been based on occupation, but Townsend and Davidson (1992) state that a weakness to this approach is that factors such as income, wealth, housing, education, behaviour, family networks are left out. Class based on occupation, in their opinion, has just been a convenient means for statistical measurement and analysis. They call this approach artefact explanations, as health and class are artificial variables and their relationship may be of little significance.

Graham (1985) believes health and wealth follow Britain's social structure highlighting class differences in living standards and life chances. Sociologists argue against using the grading of occupations, for example, doctors above secretaries, secretaries above factory workers, and believe class embodies the unequal positions people hold in society (Graham, 1985). Class based on occupation has strength in its ease of use, but can be inaccurate such as a self-employed manual worker can be very wealthy. Therefore, an assumption is made on income, wealth, social standing and economic position in using this approach. There is a need to untangle class from representing socio-economic position and look at multi-factorial causes.

It makes more sense to speculate that those on a lower income may not be able to afford healthy foods, but this does not necessarily mean they are unhealthier if they look after themselves in other ways like exercising. The Welsh Assembly Government (2005) found that 18% of the working age population were in receipt of benefits compared with 13% in Britain as a whole, and average gross weekly earnings were 87.7% of Britain's as a whole, 24% were economically inactive compared to 21% for Britain as a whole. Therefore, they believe evidence suggests a strong relationship between income and health inequalities. Also, that increasing income at the bottom will increase the health of the lower social classes. The Welsh Assembly Government (2005) does acknowledge that income can only partly explain health inequalities.

A strength of improving income can be assumed as there is more disposable income to choose a healthier lifestyle, to afford transport to better jobs, afford better housing etc. A weakness is that no matter how much money a person has they can still choose an unhealthy lifestyle which may impact on their health. Some social scientists argue that poverty and ill health is a product of their own culture, biology and personality, so it is more due to the individual's choices, genetics and culture of where they live having a health impact than actual income (Graham, 1985).

Townsend and Davidson (1992) explain the cultural/behavioural approach places health inequalities on individual responsibilities for example, a lifestyle of smoking, binge drinking, lack of exercise and obesity. However, cultural explanations, they

point out, can be embedded in social structures as well lack of education and sports facilities in an area. This explanation's strength is that it spreads responsibility for health inequalities between the individual, the locality's social structure and facilities, and an implied lack of government action to change behaviour by health education and provision of facilities. Its weakness is exposed by Corr and Oliver (1997) who state it is a commonly-held belief that the best diet for the prevention of coronary heart disease is a low saturated fat, low cholesterol one but this is not supported by the available evidence from clinical trials. Therefore, individual lifestyle improvements may not work for every illness. This explanation then cannot explain all health inequalities if changing behaviour may only has a positive effect for the very few.

Wilkinson (1996) states healthier people are more likely to move up the social class scale, whilst unhealthy people move down. This refers to a natural sorting of those with less socio-economic power due to illness and who are unable to work will naturally fall into lower social class brackets. Therefore, the more unwell people at the bottom, the higher their morbidity and mortality rates will be. Townsend and Davidson (1992) also describe this explanation as class V containing the weak and frail with poor health, carrying low social worth and economic reward. Whereas those in social class I are the strongest, fittest and the most mobile to improve their economic worth. The strength of this explanation is that it draws out new thinking of illness and frailty has caused people to be in the lower classes because of their reduced economic power and not the other way around, that being in a lower social class has caused ill health. Its weakness is that one cannot generalise that those who are ill fall to the bottom of the social class. They may have assets and means to keep them at a higher level, and many can still work whilst suffering a chronic disease.

Access to healthcare and medical services may explain health inequalities, but Wilkinson (1996) says the poor use more medical services than the better off. If they are using more services is it because they are more ill or more concerned to seek help? People who die suddenly may not make any demand on healthcare services, whereas those with chronic diseases may make huge demands on services (WAG, 2005). The Review of Health and Social Care in Wales (WAG, 2003) found that

Wales has the highest number of GPs due to retire or working single-handed, have fewer dentists per 10,000 population than Britain as a whole and some GP and hospital premises are substandard, outdated, or inaccessible. This testifies to the fact of access problems to health professionals and buildings, and the review states Wales has poorer health than England with an increased expenditure of 16% more per head every year.

There appears from this evidence to be an increasing demand and reducing supply of services. However, The Welsh Assembly Government (2005) point out that service utilisation statistics should not be relied upon to identify health need. Data on health service provision, access and usage comes from various sources and cannot be controlled directly (WAG, 2005). Therefore, a weakness to this approach is lack of reliable data under direct control. Its strength is identifying health services usage and lack of facilities, but it does not fully explain health inequalities. This is because of the varied health diseases where there may be excellent cancer services for rich and poor neighbourhoods, but not for heart disease, which does not explain why one will die before the other, so generalisations based on access to services cannot be made.

Townsend and Davidson (1992) think it is important to mention materialist or structuralist explanations of health inequalities as historically exploitation, poverty and disease were associated with the urban slums of the working classes in Victorian and Edwardian cities. However, they state the link of material deprivation, exploitation and ill health can no longer be readily made today. In today's climate this explanation would mean industrial processes of hazards in the workplace and distance to travel to work. Also, to group together the role of economic and associated socio-structural factors in distribution of health.

Townsend and Davidson (1992) use additional examples of communication failures of education on healthy diet and exercise, and lack of access to leisure facilities. A strength drawn from this approach would be that it can allow for exploration of a population's environment, economy, and social structures. Its weakness is that it does not mention individual health choices and genetics may be a cause of a

disease not place, structures and poverty. Therefore, economic or material deprivation cannot be the only link to poor health. This explanation overlaps class and income explanations.

Mortality and Morbidity rates have been examined for their reliability in identifying health inequalities. Different explanations for the inequalities have been explored: socio-economic position, class, income, cultural or behavioural explanations, natural social selection, access problems and materialist or structuralist explanations. It has been found there is a strong link between deprivation, socio-economic position and higher rates of ill health or death (Townsend et al. 1988). However, this explanation is not as strong today and no one approach has adequately explained the reasons for health inequalities because weaknesses have been identified.

Recent literature has instead tried to focus on new ways of collecting data to be able to take a multi-factoral approach in examining the real experiences of health. Instead of using mortality and morbidity rates the Welsh Assembly Government (2005) aim to tackle health inequalities by a direct needs approach. This is based on the Welsh Health Survey giving detailed information on 30,000 people's health through interviewing techniques. This is used to distribute the budget among hospital and community health services at a local level of what is needed.

The Welsh Assembly Government (2005) adopted five health target areas to focus on: heart disease, cancer, child health, mental health and health of older people. They advocate using a principle of equity and aim to reduce the difference between the health status of the most deprived 20% and the least deprived 20%. This has the benefits of analysing health experiences on a local level, having local policies and strengthening communities. In 2001 they set up the Inequalities in Health Fund (WAG, 2005) to stimulate and support local action against inequalities in health. The fund has supported 62 projects in disadvantaged communities across Wales.

Townsend and Davidson (1992) say it is a positive development to plan healthcare on basis of health need in a population. They warn of the danger of employing a business ethos and turning to the private sector for help. The NHS is unique and

health inequalities should be examined at local level and local action taken to ensure those in deprived areas have equal access to services, health education and are encouraged to take responsibility for their own health.

Overall, one can conclude that preventative strategies are needed to target statistics of poor health for the next generation in a given population. The inequality explanations all need to be bunched together in a multi-factor explanation, but most importantly with a better informed public, choice should be an important explanation. If one is given money and access to services it does not mean that they will choose a healthier lifestyle and access those services, they may choose not to be pro-active about their health. Therefore, health inequalities remain complex. Health inequalities have then existed for decades as evidenced by the different reports and policies, but it is indicated that little progress has been made to reduce them. The devolving of powers by the central government to Wales can be seen as a step to enable health service provision according to local population needs (Wales Office, 2012).

It is clear that the central government has responded to the 'Wanless Report' (DH, 2002) to take the health service into the 21st century where there will be a growing elderly population living longer with chronic diseases. They intend to expand intermediate care services with £900 million investment, set up one-stop primary care centres and end the postcode lottery in patients receiving treatment. From political action in more white papers 'A First Class Service' (DH,1998a), 'The New NHS: Modern and Dependable' (DH,1997), 'Saving Lives: Our Healthier Nation' (DH,1999b), came the creation of the National Institute of Clinical Excellence to standardise healthcare across the UK and issue guidance on cost effective treatments through National Service Frameworks. The Commission for Health Improvement was also created to inspect NHS care providers with the aim to drive up the quality and standards of care.

These initiatives come under the umbrella term clinical governance, which includes risk management, auditing and clinical supervision to improve standards (Donaldson and Scally, 2009). Thus, these political measures put pressure on the healthcare workforce to change and modernise. The Welsh Assembly Government published

'Designed for Life' (WAG, 2005), responding to the central government's white papers to improve healthcare standards over a ten year period and reduce inequalities in access to healthcare in Wales.

All these drivers brought a wealth of posts to nursing for example, the growth of intermediate care and a shift of resources to increase care delivery in the community to free up hospital beds (First Local Health Board & Anytown NHS Trust, 2006). The Department of Health issued guidance on chronic disease management for the health service to meet the demands of demographic changes in the 21st century (DH, 2004; DH, 2005a; DH, 2005b). The policies were needed as statistics showed the South Wales valleys had a higher percentage of people reporting a long term illness than England (WAG, 2005).

In Wales, one in six men and one in five women were treated for hypertension, one in eight men and one in seven women had respiratory illness, 27% of men and 26% of women smoked, 28% of men and 12% of women binge drink, and 59% of men and 49% of women were overweight (Health Statistics Wales, 2006). Therefore, in recent years Wales has been viewed as having poor health and unhealthy lifestyles, with the main causes of death being 38% due to the circulatory system, 27% due to cancer, 13% due to respiratory disease (Health Statistics Wales, 2006).

In Wales, Local Health Boards were awarded 'Wanless' funds to set up a team of long term conditions nurses to improve chronic disease management and reduce hospital admissions (NHS Wales, 2006). These nurses would work in the community in collaboration with GPs, but also cross boundaries into the hospital to ensure continuity of case management care. Thus, were classed as intermediate care workers.

Already in existence were primary care workers such as district nurses, GPs and fractured teams of therapists delivering care to the community. In 2010 the Welsh Assembly Government published 'Setting the Direction', which was a strategic framework to assist Local Health Boards in the delivery of improved primary care and community based services for their local populations. This strategy was aided by

the creation of seven Local Health Boards in 2009 to bring together primary, intermediate and secondary services within a unified organisational structure.

Weaknesses such as the interface between local services provided by GPs and hospital services delivering a patchwork of service provision were highlighted. Also, that organising care at home had become so complicated it was easier to admit a patient to hospital (WAG, 2010). In 'Setting the Direction' (WAG, 2010), there was a call for care to become preventative rather than crisis management, which echoed the policy priorities of the 1990's (Ham, 2009). Therefore, it is in this policy (WAG, 2010) that the required need to form a Community Resource Team comes into being. This Community Resource Team will merge clinical experts who were existing in fragmented sections of intermediate care, but not working together. The vision is to achieve a coherent system under multi-agency locality leadership.

A policy background and a discussion on health inequalities in Britain have been presented. Along with the history of the NHS and intermediate care, this gives us a holistic viewpoint of the setting into which intermediate care emerged and became a solidified section of the NHS. In summary it is clear from the historical and policy perspective of the NHS that it is a complex organisation. One main theme from the above evidence is that of managing a system of health care with finite resources in a world of increasing demand.

The NHS has had to adapt and change in response to demographic, political, social, financial, technological and professional pressures. Within this system intermediate care exists for care that was fragmented in its delivery, but now given more importance to group together its resources into one subsystem (see Diagram 1). The purpose of this is to meet the demands of the 21st century of shifting more care to the community because it is more economical and cost-effective than care delivered in hospitals (WAG, 2010).

DIAGRAM 1 - NHS SYSTEM OF CARE DELIVERY



**COMMUNITY &
GP SURGERIES**

**PATIENTS' OWN HOMES,
RAPID ACCESS CLINICS,
& DAY HOSPITALS.**

HOSPITAL



UNDERPINNED BY WORKING IN PARTNERSHIP WITH SOCIAL SERVICES.
HAVING ACCESS TO EQUIPMENT STORES, PATHOLOGY LABORATORY, AND
X-RAY FACILITIES FOR INVESTIGATIONS TO ENSURE RAPID ACTION
REGARDING RESULTS TO PREVENT HOSPITAL ADMISSIONS AND
FACILITATE DISCHARGE.

1.2 Research Problem/Question

From the discussion so far it can be seen that the NHS has evolved in the 21st century from a two sector delivery system of primary and secondary care to three sectors with intermediate care sitting in the middle to alleviate pressures on both areas. A separate specialist sector is that of tertiary care concerned with the provision of palliative or specialist care services. In order to compare the new initiative of care at home (intermediate care) as opposed to the traditional system of health care in hospital (secondary care), the patients' journeys in both settings have been examined in this research. The overall aim was to ascertain if intermediate care is delivering its objective to provide a successful outcome for the patient in a new care setting as opposed the traditional one. It is acknowledged that patients can have positive or negative experiences along their care pathway to a successful outcome which this research investigates.

The research study informs on how a community service is delivering the new health agenda and, most importantly, how the patients feel and perceive their journeys through community based care and hospital based care. There is no point introducing a health service change which is ineffective and does not allow for a successful outcome for the patient. Therefore, the patient as the service user should be able to provide feedback to ascertain the service's effectiveness in meeting their needs.

This study aimed to explore how patients felt receiving their care in a different setting. Some people may feel they are entitled to go to hospital after years of paying national insurance contributions. However, in this study no patient felt their care was inappropriately delivered at home or felt like second-class citizens that they did not occupy a hospital bed. Staff members felt like they were delivering the right care, at the right time and in the right place. This type of feedback is crucial to evaluate how effective a service is and to plan future resource allocation.

It has been evidenced that the central government has shifted financial resources into intermediate care (DH, 2001) so feedback is needed that it is a cost effective alternative type of care producing a quality outcome. Who better to ask about this

service than the patients themselves who are in receipt of this type of care and staff who are assessing them or delivering their care at home? By way of qualitative inquiry a detailed account will emerge on the intermediate care pathway experience in order to answer the above questions. Ultimately, it will be revealed if this type of service is successful in relieving the demographic, financial, social, growing ill health and technological pressures we face in the modern NHS.

1.3. Justification for the Study

Government policies, the history of the NHS and the state of public health over recent decades have been discussed. It is interesting to see the NHS as a complex organisation which has had to adapt to change. In practical terms the creation of the Early Response Service within the remit of intermediate care in the research locality would have been decided on by a team of professionals from secondary, intermediate and primary care. How this service would interact with each of these subsystems already in existence would have been anticipated. Also, the knock on effect of demands put on other services, resources such as increased availability of commodes and bed levers at home and the costs offset against the cost of saving a hospital admission would have been examined. The very nature of the Early Response Service existing within intermediate care would require voluntary cooperation by all agencies at the interface between primary and secondary care.

Pslek and Greenhalgh (2001) state that the science of complex adaptive systems provides important concepts and tools for responding to the challenges of health care in the 21st century. Intermediate care has come about because of challenges the NHS faces on its care delivery methods and this study reveals how it is helping relieve pressures on primary and secondary care. The benefit of this is that policy-makers can see if the changes introduced to deliver an alternative type of healthcare is successful or not. The cost in not performing this study is the not knowing how a locality is performing against health service initiatives beyond the collection of quantitative data from routine audits.

Kast and Rosenzweig (1985) state that goals should be stated in general terms so there is room for organisational participants to fill in details according to their own

perception and to modify the pattern to their own liking. This infers that even though general goals will be stated by government policy how this is interpreted at local level may be different amongst communities based on their population needs. It is useful to investigate and explore how this locality has interpreted intermediate care objectives as other localities can learn or benchmark their practice against this. Also, to discover if there were any unintended consequences of shifting care into the community like what happened to mental health services in the 1960's where it was poorly organised (Koyanagi, 2007). This study provides important feedback to planning health resource allocation to know the consequences of a new care pathway.

Rittel and Webber (1973) state that a problem cannot be understood without knowing about its context. The context for the patient who utilises the Early Response Service is that they have both health and social needs. Therefore, the whole system needs health and social care to work together. Allen et al. (2004) found in a case study that inter-agency working was complex and can fail the patient. The different professionals can either merge their power to over-rule the wishes of the relative or carer of a patient or they can compete against each other due to their different specialities impeding progress. Therefore, the interdependence of components within a care system must be acknowledged as well as the patients' choice and opportunity to make informed decisions.

Senge (2006) warns that today's problems come from yesterday's solutions and that solutions merely shift problems from one part of a system to another. Senge (2006) uses the example of malnutrition where the well-intentioned intervention of supplying more food to decrease death rates results in an increased population with a higher demand on food and in turn more malnutrition. Thus, there is short-term benefit but in the long-term the problem endures. This is an interesting perspective in relation to intermediate care and the work of the Early Response Service to help prevent hospital admissions and care for the patient at home as an alternative to hospital. There may be a short-term benefit of reducing hospital admissions and saving money, but it is not known what will happen in the long-term.

The policy literature points to a growing number of elderly population and with finite resources, so one can speculate that the Early Response Service's work may always be with a proportion of the people who needs the service. According to 'Setting the Direction' (WAG, 2010) there are no new monies to invest in the delivery of new primary and community services. Many Local Health Boards find themselves in debt with limited expenditure (BBC News, 2012). Thus, the future of health care delivery remains uncertain in relation to economic and demographic trends. It is important to know if this care delivery model of intermediate care is working as it will inform present decisions made for the future planning of health care in the community.

It is apparent that decisions made about intermediate care impacts on primary and secondary care delivery, because if it did not exist then there would be increased bed pressures at hospitals and GPs would have no alternative other to admit patients to hospital rather than receive healthcare support in community. Thus, another justification for this study is that insights can be gained on how a service is enabling other health care sectors to utilise their resources more efficiently based on a principle of equity. That is not to take away the equality of a patient being involved in the decision if they would like their care at home, but simply giving them an alternative option if it suited their needs and this can free up a hospital bed for those with more acute needs.

The NHS as a complex organisation and how the creation of one area of healthcare affects others has briefly been discussed. It is not intended for this study to investigate further the theories of organisations or policy changes. Rather that this study remains rooted in a nursing framework because the main aim is to gain the patients' opinions of how the service has affected them. Therefore, with the intention to retain a patient focus throughout, a modern nursing theory was drawn upon.

The patient has suffered an injury and needs a holistic assessment because it impacts on their everyday functioning. Therefore, the Comfort theory (Kolcaba, 2010) and bio-psycho-social model (Engel, 1977) has been used to aide data analysis and comparisons between each group of participants. There are links between Kolcaba's (2010) theory, Engel's (1977) model and the theories of ageing from a biological,

social and psychological perspective. Utilising these three premises forms a foundation for this study in order to achieve a patient centred analysis. This type of approach is innovative in a study of this kind and will help promote a patient focus as they are the consumers of a new health service initiative.

1.4. Methodology

A service evaluation of how successful the Early Response Service is delivering their care is already taking place in the form of monthly audits. The intermediate care team in the chosen locality keep data on an 'Excel' spreadsheet of the number of patients referred every month, how many bed days were saved and what were the outcomes in terms of goals achieved. This is quantitative data and does not give the whole picture in terms of user opinions and satisfaction levels about the service. The Early Response Team has attempted to devise a short questionnaire to gain qualitative data, however just knowing if someone is satisfied with a service does not give clarity to finding out why this service is different from the traditional one and what advantages or disadvantages are gained. It is felt that qualitative interviews enables a gathering of more detailed information on the care experienced and enables a differentiation from the traditional route of care.

In order to capture the true experiences of patients using the new service of receiving care at home, a multiple case study approach of qualitative interviews with semi-structured questions is utilised. To truly explore how their experiences are different or similar to patients who have received the traditional route of care at hospital, patients undertaking the traditional route of care are interviewed also. Therefore, two groups of patients are interviewed; those who have care at hospital and those who have care at home.

It may be obvious when there is a need for hospital care in cases such as uncontrolled bleeding from injury or a myocardial infarction or some other serious health event. Therefore, these two groups of patients must have similar injuries so there will only be subtle differences as to why they took different paths of care. To explain further by giving an example, if a person falls and intermediate care did not exist and due to their injury like a broken wrist they could no longer cook or wash

themselves at home, traditionally this person would have to stay in hospital. With intermediate care in existence it is possible this person can return home with the Early Response Service helping with food and hygiene needs and save a hospital bed which in turn saves secondary care money. Therefore, the research study needed to find participants with same/similar presenting symptoms and examine the difference as to why one could have care at home and one could not. This will also help clarify the characteristics of patients who are suitable for intermediate care services.

The staff members at the forefront in A & E actually witnessing and differentiating who can be cared at home or not have important opinions to be gained. It is them who are most familiar with this new service and its capabilities. It is them who have experienced change in service provision and what they can now offer patients.

Therefore, their experiences as referrers to this new service and assessing this group of patients will give valuable insight for this study. In summary, the methodology utilised in this research to capture more detailed experiences of new and traditional routes of care is that of case study method. Ten patient participants will be interviewed encompassing five from the hospital care group and five from the home care group. Also, the ten members of staff who were involved in their assessment and care provision will be interviewed. It is felt this method will reveal rich data in order to examine how successful the new intermediate care initiative is above that of audit level.

1.5 Outline of the Thesis

Following on from this introductory chapter, chapter two will present the concepts and chapter three the theoretical underpinning of this research. The thesis is about intermediate care so there is a need to explore it by way of concept analysis for the reader to fully understand its definition and what this type of care it encompasses. Next a discussion will take place on the theoretical framework underpinning this research. This is professional doctorate pertaining to nursing which traditionally was associated with the medical model of care. However, in terms of delivering holistic care to the patient it is not just the physical injury that needs to be examined. The

underpinning theory needs to allow an in-depth analysis of how an ill health event has affected a person in terms of their everyday functioning which includes other factors such as psychological, social and environmental factors.

Chapter four will present a literature review on other research studies in intermediate care. This is important as it explores where this research will sit as a body of evidence in this area of care. Also, this chapter is important as to ascertain what themes emerge from literature such as age discrimination and loneliness that will be relevant to the data analysis.

Chapter five will look at the research design and methodology. Chapter six presents the data analysis from the qualitative interviews. This chapter will also look at what themes has emerged and the results in terms of the theoretical underpinning. It will give the reader an insider perspective on what it is like to experience intermediate care. Chapter seven is a results chapter in relation to the research questions or 'mental framework'. This is an important chapter as it will relate the results to answering the research questions and on a macro level show the context of intermediate care in a wider perspective of health service provision. Chapter eight contains the conclusion, discussion and recommendations for practice.

1.6. Conclusion

In conclusion this introductory chapter has introduced a synopsis of the main body of the study. It has presented the background to the research in broad terms and then focused in on what the research study is about. The historical and policy context of this study was important to find out as it informs on how the present sector of intermediate care, which is to be explored, has come about. It has been learnt that intermediate care is an important part of a whole system of NHS care delivery and that how this area performs impacts on other areas such as primary and secondary care. More importantly, the patient focus of this study has been introduced and the need to embed this study in a holistic viewpoint of patient needs as to why they were utilising the intermediate care service.

CHAPTER 2

CONCEPT ANALYSIS OF INTERMEDIATE CARE

2. CONCEPT ANALYSIS OF INTERMEDIATE CARE

2.1. Introduction

Definitions of primary, intermediate, secondary and tertiary care have been presented in chapter one. It is necessary to explore further the concept of intermediate care to understand the Early Response Service which sits within this care area. Therefore, this chapter will firstly analyse intermediate care as a concept which will help the reader understand the next section which describes how the Early Response Service works.

Bryman (2008) describes a concept as a building block of theory or a label given to elements of the social world that have a common feature. He warns of arriving at a definitive definition of a concept as it must be allowed to evolve with time and new information. The author agrees that whatever conclusion is arrived at in defining intermediate care it must be acknowledged that what intermediate care is today may be different tomorrow. Therefore, it is a dynamic concept changing in response to needs placed upon it.

Avant & Walker (1995) see concepts as mental constructions with defining attributes that enable us to make sense of our environment. Avant & Walker (1995) agree that the concept analysis' final definition must be viewed tentatively as two people may come up with different attributes for the concept. Therefore, the analysis on intermediate care must be rigorous and common characteristics pulled together to form a criteria for the concept. This ensures the most accurate definition is reached for the reader to understand.

The aims are to clarify the meaning of the term and to distinguish it from the traditional areas of primary and secondary care which exist within the NHS system of care delivery. Avant & Walker's (1995) concept analysis framework of eight steps will be used to search literature sources on intermediate care. This framework was

chosen as it enables a pulling together in logical steps of what evidence has been discovered to construct a more informed definition of intermediate care. Also, speculation will take place on the future of this discipline. Therefore, the learning outcomes are that a holistic definition of intermediate care with defining characteristics is reached along with an understanding of the reasons for its existence and possible alternatives to this type of care.

2.1.1 Concept Analysis of Intermediate Care

Avant and Walker’s (1995) concept analysis promotes eight steps of defining the concept’s characteristics, this in turn produces a cluster of associated attributes which can be developed into a criteria. These criteria will differentiate the concept from others and its characteristics should then be easily seen in a variety of literature. Their analysis technique is based on Wilson’s (1969) concept analysis of eleven steps. Step one of choosing a concept and step two of determining the aims of analysis have already been addressed.

TABLE 3 – AVANT & WALKER’S 8 STEPS OF CONCEPT ANALYSIS

STEP 1	Choosing a Concept
STEP 2	Determining the Aims of the Analysis
STEP 3	Identify All Uses of the Concept
STEP 4	Determine All Defining Attributes
STEP 5	Construct a Model Case
STEP 6	Construct an Illegitimate Case
STEP 7	Antecedents & Consequences
STEP 8	Define Empirical Referents

Step Three - Identify All Uses of the Concept

In the English dictionary (2008) ‘Intermediate’ is defined as in the middle or in between. ‘Care’ is defined as a concern, or to feel consideration, regard, or to provide for. Therefore, in its simplest terms it is defined as a middle area which provides consideration. It is necessary to explore the literature to learn more about this middle area of care. Penrod and Hupcey (2009) state concept analysis is needed to find out exactly what something is in the current state of science.

Increasingly throughout the UK, areas of health service delivery have been grouped together under the label of intermediate care. It is perceived as something in the middle between primary (community) and secondary (hospital) care and between acute and chronic care delivery. Already other concepts such as primary and secondary care are being expressed in terms of language, to differentiate intermediate care. Avant and Walker (1995) explain that one progresses from a concept to a causal statement explaining the cause and effect relationship. One can infer that primary, intermediate and secondary care are inter-related. Primary is understood as the community category. Intermediate is the middle area of care need which primary cannot help. Secondary is the area that neither primary nor intermediate care can help. Also, language used such as acute care belongs to secondary care, not acute and not chronic belongs to intermediate care and chronic, long-term, less urgent care belongs to the primary care label. Therefore, everyone has subjective ideals or concept images that allow us to categorise and communicate our environment to each other (Avant and Walker, 1995).

If a patient's care need does not fit into the category of primary or secondary, then they must fit into the category of intermediate. This assumes a default position.

Salford Intermediate Care Services defined itself in 2009 as being,

“provided in a range of settings including people's own homes and will provide time limited interventions as a response to an episode of need; within a rehabilitative and enabling culture (physical, psychological and social); designed to prevent avoidable hospitalisation or entry to long-term care; achieving prevention interventions with those whose needs may predictably lead to a loss of independence or crisis at some point in the short to medium term (i.e. 12-24 months).” (p1:2)

This definition can be interpreted as a need has arisen that threatens a person's independence and could cause a hospital admission to secondary care. Therefore, rehabilitative and enabling services are provided to help the person regain their independence. There is no mention of the professionals who are involved in care delivery. Also, patients' choices, if they wanted to go to hospital are their rights respected? Regarding a range of settings, does this include intermediate care beds at a hospital? Thus, this definition needs further clarification of the terms used within

it. However, it does explain that intermediate care is necessary to prevent secondary care taking place, and it is not a type of long term care.

In comparison, The Oxford and Anglia Intermediate Care Project (2009) definition is a service that does not require the resources of a general hospital, but are beyond the scope of the primary care team. This definition excludes hospital care, but identifies a group of clients whose needs are too complex or are not being fulfilled by the traditional primary care team (GPs, district and practice nurses). This indicates that some patients in the past could have been over treated in hospital or undertreated in the community. A need has arisen to bridge the gap and deliver effective healthcare to people who do not fit into the labels of primary and secondary care. This definition fits well into the concept's characteristic of being in the middle.

Intermediate Care Services (ICS) in Scotland (2009) produced a definition which is more explicit in naming the settings.

“The services can be provided in a range of settings including:
Individuals own homes including sheltered housing and very sheltered housing, NHS day hospitals and LA day centres, designated residential and nursing homes and community Hospitals”. (ICS Scotland, 2009, p2)

This gives more accuracy to care in hospitals, as community hospitals do not provide acute care, so intermediate care patients are defined as not needing acute care services. The mention of nursing homes is interesting, as this is usually long-term care or do they mean for the purpose of respite and rehabilitation with a view to the patient returning home? This warrants further clarification. A new dimension in this Scottish definition is the mention of health and social care working together in partnership. Therefore, the patient's needs may not just be health care, but social care like housing, financial, carers to support independence like assisting with meal preparation.

In reviewing policy literature for definitions, 'The National Service Framework for Older People' (DH, 2001) published standard three labelled 'Intermediate Care'. The aim of the standard is to provide integrated services to promote faster recovery from illness, prevent unnecessary hospital admissions, support timely discharge and maximise independent living. It refers to 'The NHS Plan' (DH, 2000c) to promote

independence for older people through health and social care services working in partnership. Also, that by 2003-2004 an investment of £900 million will have occurred for intermediate care services. More recently, the National Audit of Intermediate Care Report (NHS Benchmarking, 2012) found investment in intermediate care averaged £1.9million per 100,000 population in 2011-12.

The policy domain has brought new understandings of intermediate care; that it is part of the health service budget, that it is included in central government health plans, and dates of 2001-2005 where the term is used as a recognisable label with its own philosophy of care. Standard three's (DH, 2001) existence means that central government has imposed standards of intermediate care on localities throughout the UK. This has acted as an impetus for setting up intermediate care services throughout the UK, grouping existing separate services under one label and creating new teams of professionals to deliver its agenda. The standard mentions professional accountability, drive, leadership and also effective coordination. Therefore, intermediate care contains a management structure to lead the service.

More recently the Community Nursing Strategy for Wales Consultation Document (WAG, 2009a) includes recommendations of health organisations developing access to fast track multi-disciplinary and multi-agency assessment in community settings to reduce hospital admissions. However, the label intermediate care is not attached to this even though it seems to fit into what is emerging that it is about. Therefore, from discovering what intermediate care is we can discover additional principles or services that fit the label. Avant and Walker (1995) call this concept derivation where one can find a concept's characteristics in literature without the use of its label. Therefore, we can apply the label to it as it fulfils its characteristics' criteria.

Step Four – Determine All Defining Attributes

Intermediate care characteristics have been found from a variety of different sources. It is apparent that the concept is used for a range of health and social care services with the aim of preventing unnecessary hospital admissions and enabling independence. It takes place in community settings like the patient's home or non-acute hospital beds. It requires a leader and a range of professionals working in

partnership. It is a time-limited intervention of rehabilitation and enabling. It is part of the government's health plans and expenditure. There are policy documents giving guidance on standards of intermediate care that must be achieved. The needs of the service users are not met by the traditional primary and secondary teams. Also, it is a recent phenomenon based on findings of ineffective care delivery and how best to meet the needs of people who are in-between the requirements of hospitals and home services. Therefore, the concept of patients and services being in the 'middle' area or service gap serves to define intermediate care. These are the defining characteristics of intermediate care where criteria have been formulated.

Key phrases from the characteristics which can inform the criteria are to prevent unnecessary hospital admissions, community based enabling interventions by a team of professionals from health and social care, maximising independence, short-term input, partnership and government funded. Therefore, patients who need acute or long-term care fall outside these criteria. One criterion that should be added is the patient's choice and co-operation in attaining rehabilitative goals. This is justified in the event that the patient refuses to be treated at home and they are unwell. The World Health Organisation's (2012) 'The Right to Health' constitution advocates entitlement to appropriate health care but does impose restrictions on which settings health care should take place. Also, if the patient is not motivated to take part, for example, in physiotherapy sessions to improve mobility at home then that rehabilitative goal will not be achieved. Thus, a patient centred criterion must be added.

Through concept analysis, concept advancement has taken place. Penrod and Hupcey (2009) strongly believe that the purpose of concept analysis should be to advance the concept to help progress the nursing body of knowledge. There may be differences between intermediate care teams across the UK in length of time involved with patient and how many professionals they can afford within their local budget. It is also dependent on other professionals such as GPs and A & E staff referring to the service, so it needs to sell its service and raise awareness in local communities of its existence.

There also exists intermediate care medical Consultants in areas such as 'Anytown' and 'Newtown'. This is a vital resource for GPs to obtain expert geriatrician opinion before making the decision to admit to hospital or not. Therefore, an awareness of the service, collaboration and co-operation of a range of professionals is needed. A positive factor is where local health changes have been proposed, a consultation document has been released by local trusts and local health boards to give opportunity to the public and professionals to comment (NHS Wales, 2006).

Steps Five & Six – Constructing a Model Case and an Illegitimate Case

Reflecting on the discussion so far, the characteristics have been analysed and criteria formulated. The understanding of this concept has been increased. However, the patients' understanding of this new service is not found in the literature. It is necessary to examine a case study of a patient going through the intermediate care pathway and the traditional route before intermediate care existed to compare the advantages.

Mrs T has suffered a fall at home and has waited several hours to be found by a neighbour. The neighbour phoned an ambulance and Mrs T was admitted to hospital. Firstly, she was assessed in the A & E department. No fractures were found but there were concerns regarding her poor mobility so she was admitted to a medical ward. She waited for a peripheral community bed to become available where she could receive input from a multi-disciplinary team (MDT) of experts to rehabilitate her so she was safe to go home. The total hospital stay equalled four weeks. The Early Response Service (2009) approximated the cost of a hospital bed at £150 a day inclusive of all care and hours of professional input, so this would have cost £4200.

Using the intermediate care services Mrs T would have been found quicker as she could have pressed her lifeline alarm to alert an operator to fetch help. Ambulance personnel are now trained that if they feel there is no definite fracture then an admission is not necessary and they can directly refer to Age Concern volunteer services or intermediate care for help for this lady at home. If they cannot rule out a fracture then Mrs T is taken to A & E for x-rays. Whilst there, not only she is

assessed by a nurse and doctor, but also by an occupational therapist and physiotherapist. With no fracture found the MDT refer her to intermediate care nurses who have a four hour response time. Mrs T is discharged home and the nurse meets her at the home.

Other team members such as the physiotherapist, occupational therapist and social worker also assess Mrs T. Equipment is provided to enable Mrs T's independence at home and carers immediately attend twice a day to help with meal preparation and personal hygiene. Mrs T receives four weeks of rehabilitation at her home and has thus avoided a hospital admission. The approximate cost of this includes x3 nurse visits, x2 occupational therapist visits, x1 social worker visit and x 5 physiotherapist visits (each of one hour length at £12 an hour) and 2 hours (£7 an hour) of health care support worker visits every day for four weeks would total £524 excluding equipment rental. Thus, it can be seen that occupying a hospital bed unnecessarily where there is a cheaper care alternative is advantageous to save the NHS money.

The link between A & E and intermediate care is crucial to the success of identifying appropriate patients who can be helped in this way instead of taking up a hospital bed. The importance of saving bed days and hospital resources can be understood and it is approximated that intermediate care providing this service is cheaper than the hospital. Also, the psychological benefit of being in one's own home avoids the disorientation and institutionalisation some patients experience whilst in hospital (Greig, 2013).

It must be acknowledged that intermediate care may not be suitable for everyone. It is helping ease pressure off secondary care by facilitating early discharge and by preventing inappropriate admissions. It does actually exist in the middle as an alternative service to the more traditional ones of primary and secondary care. Illegitimate cases are, for example, if a patient has a leg ulcer that needs dressing a district nurse can meet this need in primary care, or if an asthma review is needed a practice nurse can do this in primary care. If a person has an acute asthma attack and cannot breathe properly then they need secondary care acute services, or if a

person has central, crushing chest pain they need the acute services of secondary care with specialist equipment and personnel.

Acute cases will attend A & E and be rapidly assessed by a medical doctor with nurses following the doctor's instructions for administration of possible life-saving medications. The person with chest pain would attend the specialist coronary care unit and may need thrombolysing if they have suffered a heart attack and close supervision (NICE, 2010). Recovery would be spent on a medical ward receiving cardiac rehabilitation and careful titration of medications to prevent further heart damage. Therefore, these patients with an acute need that potentially is life threatening are not suitable for intermediate care or care at home as the specialist services and equipment do not exist there.

Step Seven - Antecedents & Consequences of Intermediate Care

The consequences of intermediate care are apparent in the above case study. The patient can be looked after in their own home, they receive health and social care input to achieve independence or regain the former level of functioning. A hospital admission has been saved, so money has been saved. One can infer that a more acute patient is now residing in the bed that Mrs T could have occupied, instead of possibly waiting on a trolley in A & E for a bed to become available. This indicates that secondary care criteria have previously been breached by non-acute patients as they have had nowhere else to go or no-one else to look after them.

A blame culture can develop between health and social services if a patient is medically fit for discharge but there is no care in the community to look after them, and the patient unfortunately becomes known as a 'bed blocker' (Dunning, 2011). Therefore, the consequences of intermediate care serve to alleviate pressures on other services and help re-sharpen the boundaries of other labels of care primary and secondary. It is imperative that there is joint working between health and social care to make the whole system of care delivery across primary, intermediate and secondary care boundaries work (Dunning, 2011).

The antecedents for the patient to be classified as needing intermediate care have already been discussed. A health or social need must occur that puts them at risk of hospital admission that threatens their independence and a need that primary care cannot cope with. It is apparent that primary and secondary care had limitations on what they could offer patients and intermediate care fills this gap. Also, there has been a growing, older population which could have widened this middle area of need (National Statistics, 2009b). If intermediate care did not exist then inappropriate hospital admissions occurred because of an ineffective primary care team failing to meet re-enabling needs. The NHS provides free health care which is a continual strain on financial resources. Therefore, it makes sense to change services to deliver resources more appropriately to population needs. Thus, we need to know the origins of intermediate care and the wider context of its purpose, most of which was discussed in chapter one.

In the 'Newtown Clinical Futures' consultation document (NHS Wales, 2006) explanations for health delivery change is put down to inequalities in access to treatment, particularly with long term conditions such as asthma, diabetes and heart disease putting more pressure on existing services. The document describes an over-reliance on district general hospitals, with long waiting times, when some services could be effectively delivered nearer to home. An interesting point is that specialist services such as intensive care need specialists who retain skills by seeing only specialist patients based on a critical mass of over 500,000 people. In other words, for this particular locality there cannot be specialist services in all hospitals, but in one specialist hospital. The document states their objective is for patients to "see the right person in the right place and at the right time" (p7).

The 'Newtown' area propose three levels of care: level one in patients' homes and community to prevent ill health and promote independence, level two is local general hospitals focusing around general and routine care and level three is specialist and critical care services for people who are seriously ill or who have complex needs. The document has given an insight into the present situation in a particular region, the reasons why change is needed and the plans for future health care. Intermediate care fits into level one category, but is referred to as 'integrated services' of

reablement and rehabilitation. This review of healthcare helps us understand the context in which intermediate care exists. One can interpret from the evidence that in the 21st century there has been a shift of focus to strengthen community services to ease the tension on secondary care hospitals. Obviously, cost-effective services and budgeting are also factors.

The publication of the 'Wanless Report' (DH, 2002) had a great impact on influencing health and social care plans. The report found that optimum health care delivery can be achieved by spending on preventing ill health and maintenance of good health. This approach advocates early intervention and rehabilitation to avoid hospital admissions where possible. Therefore, a need has arisen to strengthen community services to achieve this. Thus, the origins of intermediate care have been found along with the reasons it came into being and its aims.

Step Eight - Define Empirical Referents

Empirical referents mean the attributes of intermediate care that can be observed. These could be a physiotherapist practising going up stairs with a patient who wants to return to sleeping on the second floor, an occupational therapist helping with kitchen activities or instructing on how to use a bath board or a nurse explaining medication to a patient. The referral form route from a professional, faxed to intermediate care, the discussion of it and resulting initial assessment of the patient can be observed to discover the pathway through the service and how the patient's goals are formulated. The achievement of re-abling goals can be observed by the professional re-assessing the patient's ability with tasks at six weeks or through the evaluation paperwork. Statistics on patient throughout, discipline of professionals needed and outcomes are all collected to form part of an annual report for the local health board and any other stakeholders like local councils. Therefore, empirical referents give the finer details to the concept's characteristics to determine its existence in the real world (Avant & Walker, 1995).

Empirical referents allow for a differentiation from other ways of working. The obvious other perspective is to revert back to traditional ways of working with primary and secondary care only, but evidence has been presented to challenge that this is

ineffective. Another perspective is that of modern technology like telecare, for example, not only a lifeline alarm, but a flood alarm, smoke detectors, fall alarms and motion sensors. However, you still need a central control operator who can raise the alert for someone to respond.

In the last century it may have been reasonable to expect family members to provide this intermediate care at the patient's home such as help with hygiene needs and meals. However, with changing demography and a more mobile population family are not always near or willing to support relatives (National Statistics, 2009a). Therefore, more analysis is required into role of the family when they have a sick relative and how this has changed over recent years as it may have caused an increased demand for health and social care at home. Therefore, the concept of intermediate care can be recognised as different from other care delivery methods that exist alongside it.

Conclusion of the Concept Analysis

Avant & Walker's (2005) concept analysis has helped give structure to analyse the term intermediate care in literature and practice. A more informative and accurate definition has been reached. Varying and common characteristics have been examined, along with tracing its origins and discussing alternative care. The alternative approach of post-modernism would have examined the power behind the knowledge of the dominant perspective. Local policies and health service changes can be traced back to central government policy. However, central government policy is based on reports such as the 'Wanless Report' (DH, 2002) and National Statistics (2009b) to inform policy. In turn these pieces of evidence are research funded by the central government on localities throughout the UK. Therefore, power and knowledge held by central government in the production of national policies are based on localities' population evidence. How this evidence is interpreted is down to the individual policy writers, whose documents have to go out to public consultation. Therefore, it is as fair as one can possibly make it. At present intermediate care is working and having an impact. However, its success over the next twenty years will have to be proved if future funding is to be secured.

It is interesting to speculate how this concept may evolve in the future. The 'Wanless Report' (DH, 2002) findings influenced current health care thinking which gave rise to the concept of intermediate care. In the future there may be other diseases to tackle, more demographic changes, a pandemic which drains resources from funding intermediate care. Therefore, health care emphasis can change to meet the needs of society or to meet the needs that is predicted for the next twenty years (DH, 2002).

Intermediate care is succeeding presently in making a small impact to hospital admissions and length of stays. It can help free up bed-blockers if the person meets the criteria of needing rehabilitation. However, one cannot rule out that in the future intermediate care services may all be housed in one building and if so, will it just be a newer, more modern rehabilitation service than what used to exist in community hospitals? An important point is that the NHS can and has survived without intermediate care in the form of primary and secondary care. Therefore, it has to make itself something dynamic, something that is needed and evidence its successes to continue having a slice of health service spending.

A future scenario could be that a locality has a specialist hospital, a community hospital, GP clinics and an Intermediate Care Centre. Within this centre can be a walk-in clinic where highly skilled nurses assess conditions to ease the burden off A & E and GP surgeries, and to signpost to medical help if appropriate. There could be a multi-disciplinary team who go into the community, but they also have facilities at the base to offer clients. For example, hydrotherapy, different equipment to try like type of wheel chairs, rise and recline chairs, aimed at enabling independence.

Long term conditions nurses can be housed at this Centre, case managing patients to prevent deterioration of their conditions which may lead to hospital admissions. Social workers can also be based there to immediately intervene if a social crisis becomes evident such as housing. There can be one single point of access to this centre where other health and social professionals can refer. With funding it can become a microcosm of what future care will be like and to utilise modern technology. Concept analysis has taken place at this moment in time, so intermediate care characteristics may change or advance in the future. Therefore, it

needs to be a flexible phenomenon existing in the middle area of care to meet population demands that primary and secondary care cannot meet.

2.2 The Early Response Service within Intermediate Care

The reader has gained an in-depth understanding of intermediate care, so it is now necessary to explain how the concept works in practice by describing the Early Response Service in the chosen locality. In August 2009, a new Early Response Service (ERS) was set up in the research locality with the objectives to prevent inappropriate hospital admissions and facilitate discharge from the A & E department. The service is made up of six nurses and six health care support workers. They have access to a multi-disciplinary team of physiotherapists, occupational therapists, social worker, speech therapist and the intermediate care Consultant via 'Hot Clinics' (rapid access out-patient clinic). The team are based at a rehabilitation hospital, but their work takes place within the community.

The aim of the nurses is to liaise with A & E staff, specifically two occupational therapists, two health visitors for older people, and a district nurse to offer a safe alternative to a hospital admission by looking after the patient in their own home. The A & E staff screen and identify suitable patients using the Early Response criteria, then fax a referral form to the Early Response team. The Early Response team telephone A & E staff to discuss the referral and have a four hour response time to assess the patient at home. Therefore the service runs over a seven day week and between the hours of 8am to 8pm. The cut off time for referrals is 16:45 hours. This is to give time for the nurse to travel, perform an assessment and put health care support workers in place if help with activities of living is needed.

If a patient has fallen and fractured their humerus they may no longer be able to attend to their personal care and meals for several weeks. If they have fractured their malleolus and they are non-weight bearing on one leg, then making and transferring food will be a problem. The nurse can start carer support immediately and undertakes a medication review to ensure adequate pain relief is reached. The nurse establishes if on-going carer support is needed and refers as soon as possible to the Early Response social worker for a care package from social services.

If any functional or mobility deficits are identified the nurse inter-refers within intermediate care to access the physiotherapist and occupational therapist. Due to the nature of rapid response to save a hospital admission these patients are given priority within the service as opposed a patient with chronic problems who is waiting for a six week home exercise programme. This is justified as usually the therapist can undertake a one-off visit to give advice and supply equipment, and one physiotherapist out of six will cover picking up the Early Response referrals.

The service aims to provide ten days of carer input before social services can take over. However, with such a demand on care packages and only a once weekly panel to award care, it can take two-three weeks to begin, so some patients have the Early Response care workers for longer than the intended ten days. On a few occasions in the first six months this has led to the service reaching capacity and having to inform A & E staff on that particular day they cannot accept any more referrals. With such a demand on the service in April 2010 more funding was awarded to employ more carers. It will also be decided if funds are available to lengthen the input of the team to beyond ten days and up to six weeks. This will decrease the need for care packages from social services just for a few weeks for example, until a plaster is removed from a limb and the person returns to former functioning.

If there are any medical concerns regarding the patient in the community then the nurse refers the patient into 'Hot Clinic' to access the intermediate care Consultant. The Consultant has twice weekly clinics at the rehabilitation hospital, so a patient may go over the ten days input if tests like x-rays, CT scans or bloods are ordered. The team of nurses are also available to the other intermediate care staff if they feel any of their rehabilitation patients warrant a nurse assessment or health advice. Therefore, the Early Response Service exists within the larger remit of intermediate care, but inter-referrals and helping fellow professionals in order to benefit patients' health takes place (See Appendix 1).

The Early Response Service can be deemed as successful in preventing inappropriate admissions to hospital and facilitating discharge as the first six months audit revealed. From August 2009 to January 2010, 153 patients received the

service, out of these two thirds (102 patients) received health care support worker assistance and the majority of these went on to receive a short-term care package. All 153 patients had a response time in less than 4 hours. Goals were met of reaching independence or improving functional ability. The audit in December 2009 showed a spike of seven re-admissions out of the 29 patients who were referred. Usually it averages one a month. On examination the staff found that out that reasons included a heart attack, a collapse, infections and two patients fell again. Obviously, it would require further examination to determine if these events were preventable and to compare this group of patients to another set, to look at re-admission figures. Since December 2009, there has not been another spike in statistics.

The service evaluation in the form of monthly audits show that hundreds of bed days have been saved which in terms of money saves the NHS thousands of pounds a month cost in bed days. For example, in November 2009, 403 bed days were saved which would have cost £60,450. Patient questionnaires collected over the first six months have all contained positive feedback. The most frequently occurring patient suggestion was for the service to be longer than ten days. Obviously, financial constraints limit being able to fulfil this need at that time. Patients are not abandoned and ethical decisions are made to continue beyond the ten days until a care package is set up or the health needs of the patient are fully met. This has a knock-on effect of carer availability and the service did achieve more funding in April 2010 to increase staff levels.

The Early Response team's data collection depicting a successful service is a starting point or theory to test within this research. To truly unfold the differences in patient care experiences it is necessary to study those patients who have remained in hospital. Therefore, this research will employ inductive and deductive reasoning that health plans have been implemented to provide a successful alternative type of care in the community rather than a hospital bed. How this change in care delivery locally has affected patient journeys needs to be explored to discover if the patients feel the service is a better alternative than being admitted to hospital and to generate any new knowledge about the care settings. The patients who have remained in

hospital with same or similar injuries need to be examined to reveal how their journeys in an acute setting differ. Therefore, two groups of patients are involved in the research; those who had their care in the community and those who remained in hospital.

2.3 Conclusion

The concept analysis of intermediate care and the description of the Early Response Service give the reader a sense of what the home care pathway will encompass as opposed hospital. The aim was to clarify the meaning of intermediate care and to distinguish it from the traditional areas of primary and secondary care which exist within the NHS system of care delivery. Next it is necessary to present a theoretical framework for the research so the results of the research can be presented from a specific theoretical stance.

CHAPTER 3

THEORETICAL

ASSUMPTIONS

3. THEORETICAL ASSUMPTIONS

3.1 Introduction

This chapter presents the theoretical assumptions of the research. It is necessary to decide on a theoretical framework for the study which helps the reader understand the underpinning of the research and helps organise the study. Theoretical assumptions provide a means of data analysis and a tool for interpreting results into a specific context of health care research. In other words there would be a different emphasis on this study if the author was from a financial, business or medical background, as opposed nursing.

3.2 Theoretical Framework

To process the data in the form of qualitative interviews with patients and staff, a theoretical framework has been useful. In summary ten patients who have suffered an injury/ill health are interviewed on their experiences of new and traditional health care services. Therefore, a means to focus interview questions as well as enable data analysis is needed. It is obvious that the desired outcome for any ill health event is a move to wellness again facilitated by health care staff. Therefore, any theory or model used must reflect this. A definition of wellness is attainment of full potential; it is holistic in nature encompassing lifestyle, spiritual and environmental factors (National Institute of Wellness, 1977). Therefore, an exploration of nursing literature is warranted to find a framework for the study that is holistic in nature.

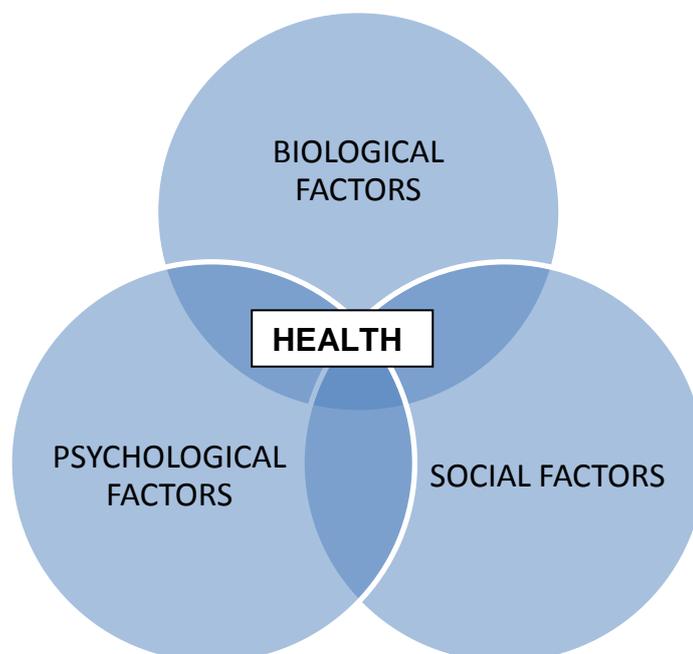
One model that encompasses the different factors that bring about wellness is the bio-psycho-social model (Engel, 1977). In view of the patient suffering a physical injury as to why they have attended A & E, a physical heading is needed to analyse data to expose the functional deficits the patient has suffered. Suffering a traumatic injury and the resultant level of coping will create stress for the patient, so a psychological heading is needed to explore this impact.

With the aim of getting the impaired patient back home a social heading for data analysis is needed. This concerns the amount of help the patient needs in day to day functioning before they reach their ultimate goal of recovery. Such social issues

include carers' help to wash, dress, prepare food, make the bed and empty the commode. Social issues also include the patients' social network such as family, friends and neighbour's help. Therefore, the bio-psycho-social model fits well the patients' journey from illness to wellness and the impact of the experiences along the way.

The bio-psycho-social model was first invented by George Engel in 1977. It arose out of a growing dissatisfaction with the biomedical model which held that disease resulted solely from the derangement of underlying physical mechanisms, and gave no attention to the role of psychological and social factors (Gabriel and Dutton, 2012). Under the biomedical model, health was defined simply as the presence or absence of disease (Gabriel and Dutton, 2012). In the bio-psycho-social model it is not only the physiological response to illness that is considered, but the psychological and social aspects in terms of capacity of the person dealing with being ill (Brown et al. 2005).

DIAGRAM 2 – ENGEL'S BIO-PSYCHO-SOCIAL MODEL (1977)



Disorbio et al. (2006) believes by assessing a patient from a three dimensional bio-psycho-social perspective, a deeper understanding of the patient's condition can be achieved and it uncovers important information for developing a treatment plan. These authors use the example of back pain where the physical aspect is the pain, resultant treatment and surgery. The psychological aspect is the associated depression and the social aspect is the loss of work and finances. If any of these dimensions are ignored, it will seriously impact the prognosis for recovery (Disorbio et al. 2006).

Epstein and Borrell-Carrio (2005) believe that each element of the bio-psycho-social model may be weighted differently dependent on the person and the situation. They explain it is not a linear hierarchical level theory but rather a web or matrices of the three elements. For example, a patient may be more concerned with missing work (social) and feel anxious about this (psychological) rather than the physical symptoms of illness (biological) they present with. However, the doctor will be more concerned with the physical presentation of illness (biological) than the social or psychological repercussions. Epstein and Borrell-Carrio (2005) believe that this is a descriptive model and should be used in a holistic sense to help practitioners consider all elements that lead to illness and the effects on the person.

Weston (2005) states a weakness of the bio-psycho-social model is that doctors find it hard to spend the time on the psychological and social elements when they are primarily there to diagnose and treat illness. They use an example of a patient leaving a consulting room happy and understood but the doctor feeling guilty and incompetent that they have missed a physical diagnosis. Weston (2005) explains that even though the psychological and social elements should be considered some authors suggest making the biological aspect a priority. However, Weston (2005) feels that if this happens then important clues to the origin of the illness might be missed. Weston (2005) advocates that physicians need more guidance in their interviewing skills as to what information they delve deeper into to discover which of the three elements is impacting most on the illness.

Further criticism is made by Tavakoli (2009) that even though the bio-psycho-social model is a good tool for teaching students to consider the person holistically, it still has weaknesses concerning overemphasising one element more than others. Tavakoli (2009) gives examples of diseases like schizophrenia being classified as a psycho-social phenomenon by psychiatrists and its physical disease state being overlooked. Also that antisocial behaviour like theft or violence can be excused as a physical disease state and treated in a medical setting instead of in psychiatry. Therefore, it is important not to focus on one element of the model, but all three of the biological, psychological and social.

McLaren (1998) defends the bio-psycho-social model by saying it legitimising the holistic approach to assessing patients by uniting the disparate elements of human life. Therefore, for whatever weaknesses have been highlighted it still serves a purpose for the practitioner to consider not only the illness, but the person themselves and their social circumstances and psychological state. It is important, in order to compare care at home and hospital, that not only the effects of physical injuries are compared but the social and psychological experiences of each patient journey. This will enable a more detailed analysis to ascertain which care pathway was more beneficial for the patient. However, three elements of wellness may not be enough to ascertain a successful health care service and a holistic analysis.

The author acknowledges that by looking at intermediate care it can encompass change theory and systems thinking theory in view of the NHS as a complex organisation. However, this is research concerning nurses' practice and examining an episode of patient care which is by a new means of care delivery. Therefore, to build on the bio-psycho-social model an exploration of nursing theories is needed. The patient needs help because the injury/illness has affected their everyday functioning or ability to care for themselves. Therefore, the theoretical framework chosen must reflect this.

There are several different nursing theories which can achieve this such as Orem's (2001) Self-Care Deficit theory, Henderson's (1991) Need theory and Kolcaba's (2010) Comfort theory. Orem's (2001) theory is concerned with the help needed by

patients when they are unable to self-care and concerns universal requisites of maintenance of sufficient air, food, water, elimination, activity, rest, social interaction, prevention of hazards and developing human potential. This theory was not chosen as the author feels it is unnecessary to have in-depth participant analysis of factors that have no relevancy to the research questions. In other words the participants are not presenting with for example breathing problems, and the focus of the study could be lost in trying to search for these factors which do not exist.

Henderson's (1991) need theory also encompasses physical, psychological and social factors and lists 14 needs. These include breathing, nutrition, elimination, posture, sleep, clothing, temperature, hygiene, dangers in environment, communication, religion, play, to satisfy curiosity and work in a way for accomplishment. This theory has not been chosen either due to the question of relevancy pertaining to the research questions. Even though a physical heading is needed, all aspects of physical or biological state do not need analysis if they are not directly linked to impact of functioning from the injury. Epstein and Borrell-Carrio (2005) warned that each element of a bio-psycho-social perspective should be weighted differently dependent on the situation. Therefore, there is a danger if this nursing theory is chosen one could become distracted by focusing on irrelevant data.

A more modern theory which can encompass the physical, psychological and social effects of injury as to why a patient requires help is the Comfort theory by Kolcaba (2010). Comfort is described as existing in three forms of relief, ease and transcendence where relief is when a comfort need is met like analgesia for pain, ease is where the patient feels contentment or that an anxiety has been addressed and transcendence is the state of comfort where the patient can rise above their challenges (Kolcaba, 2010). Holistic comfort is defined by Kolcaba (2010) as having these three needs met in the context of physical, psycho-spiritual, social and environmental experiences.

The author favours this nursing theory because it allows the physical, psychological and social aspects of the two different types of care to be explored. It is not prescriptive in stating that irrelevant physical factors to the research such as air or

temperature are to be considered. Therefore, it is more flexible to allow analysis within the context of the research. It also brings in an additional environmental aspect which is the important research comparison of hospital or home settings. Kolcaba (2010) explains environmental means any aspect of the patient's surroundings that can be manipulated by the nurse to increase comfort. This fourth area of environment, as well as the physical, psychological and social elements has been interesting to examine in the research data.

Dowd (2010) describes the Comfort theory as a middle range theory with the advantages of clarity, simplicity, generality, empirical precision and derivable consequences. Also, that it is applicable to any age, setting, culture, it is patient-centred and appears to bring nursing back to its caring roots by assessing comfort. Student (2008) states that the Comfort theory sought to explore the comfort concept in comparison to other theorists like Watson (1979) or Orlando (1961) who did not fully define it. Student (2008) favours this theory by applying it to end of life patients and says it helps raise awareness of the inadequacy of addressing the physical needs of patients only.

Its taxonomic structure was developed to guide measurement of comfort and Dowd (2010) recommends utilising a likert scale of one to ten, to measure patient comfort. However, this can be criticism of this theory as for this study to ask research participants on a scale of one to ten regarding their comfort would be too simplistic. Rather what is needed is to use the theory's framework to examine the qualitative data for comfort forms of relief, ease, and transcendence, in the four contexts of physical, psycho-spiritual, social and environmental.

Comfort theory definitions provided by Kolcaba (2010) explain that nursing is the process of assessing, developing, implementing and evaluating nursing interventions for comfort needs. Health is optimal functioning as defined by the patient who is someone in need of care in an environment of their surroundings (Kolcaba, 2010). Therefore, for the purpose of this research what we are exploring are the nursing and therapist interventions that took place in two different environments based on the needs that has arisen from the same/similar injury suffered.

In applying this theory to the research helps facilitate answers to our questions if care at home is better than hospital care, how it is different and are the patients' needs for comfort being met. The ability for the patient to reach a state of holistic comfort can reflect on how well a care service is performing in meeting needs of relief, ease and transcendence. In other words if all the home patients experienced discomfort in the four contexts of experience then hospital care could be interpreted as better or vice versa.

The Comfort theory (Kolcaba, 2010) and the bio-psycho-social model (Engel, 1977) link to the Ageing theories discovered in the literature review chapter four, which concerns ageing from a biological, sociological and psychological perspective (Hughes, 1995). This is important as the sample population will encompass the older person. In summary, three premises have been found to utilise as a framework for data analysis that refer to the components of the physical, social, psychological or environmental contexts. Therefore, the researcher is guided by these four themes when interpreting the results which will help achieve a holistic patient focus.

3.3 Conclusion

This chapter has introduced to the reader a theoretical framework as a method to organise the study and to interpret the results. The reader has gained further knowledge about the context in which analysis has taken place. The author acknowledges that so far several themes have emerged in this thesis relating to systems management, change theory and patient experiences. However, to remain in the context of nursing and focus towards answering the research questions these possible areas of further exploration have been limited to maintain patient focus throughout. Ultimately, the new way of care being delivered in the patients' home in comparison to hospital and the how the patients' perceive this care is being examined.

The holistic framework relating to Comfort Theory (Kolcaba, 2010) and the bio-psycho-social model (Engel, 1977) proves useful in maintaining patient experience focus for data analysis relating to the four contexts of comfort. To bring further clarity to the research, the patient has suffered a physical injury which has produced

discomfort and affected their own coping abilities. Therefore, they need help and some are given that help at home and some at hospital. This injury will affect all areas of their life like the ability to maintain nutrition, hygiene, toileting, socialisation and a clean safe environment, so the research methodology must aim to uncover the experiences, needs and differences between interventions.

The next chapter is a literature review on intermediate care as this is the area of care where the new way of caring for patients at home takes place. Related and immediate disciplines will be discussed. The aim of the next chapter is for the reader to ascertain where this research fits into wider health research. It will be discovered if there is any research existing similar in nature and if so what it encompasses.

CHAPTER 4

LITERATURE REVIEW

4. LITERATURE REVIEW

4.1 Introduction to the Review

Chapters one, two and three have already explored historical policy literature, concepts and theoretical underpinnings which are relevant to this research. Chapter four will look at the existence of any similar research case studies that have taken place and also explore related disciplines. The objectives are to be able to put this research in its current context, to ascertain whether this area is well-researched or is it innovative in its undertaking. Also, to look at other methodology and results from different localities pertaining to their successes and implications for practice.

This chapter is structured by looking at related disciplines before the immediate discipline of intermediate care. There are also sections pertaining to age discrimination and loneliness as the research study encompassed older adults these can be particular issues this group faces as opposed younger adults (Wade, 2004; Nobili et al. 2011). However, it was not until the literature review was performed and these articles were found by Wade (2004) and Nobili et al. (2011) that the researcher realised these issues could impact on the study.

In view of the study envisaged to encompass older adults as they are more frequent users of healthcare than young adults (DH, 2001), and the theories of aging having biological, social and psychological effects on the person, which links to the theoretical underpinning of the study of holistic care, the researcher decided to include loneliness and age discrimination in the study. Therefore they are examined as separate themes in the data analysis. This is also supported by the NSF for Older People (DH, 2001) which has sections on intermediate care as well as age discrimination concerning older people having access to health services. Important data could be lost regarding the real life experiences of the sample population if two main issues that can affect them are not considered when interpreting their experience of ill health and recovery.

The specific questions which have designed the review are to discover the prevalence of particular issues such as access to health services, resource issues,

how other areas interpreted intermediate care policies into practice in their localities, what their services consist of, and ascertain any similar research that exists on intermediate care. Each literature search section will present its own search strategy, search engine utilised, search terms, etc. However, a summary is presented in the table below.

TABLE 4 - TOTAL ARTICLES FOUND

SEARCH METHOD	NUMBER OF ARTICLES	SEARCH TERMS	DATE
CINAHL PLUS	9	AGE DISCRIMINATION	08/05/13
CINAHL PLUS	12	LONELINESS OLDER PEOPLE	08/05/13
GENERAL SEARCH OF INTERNET VIA GOOGLE	4	CASE STUDIES ON CARE AT HOME AS OPPOSED HOSPITAL	25/08/10
SPECIFIC SEARCH OF OVID MEDLINE	8	INTERMEDIATE CARE CASE STUDIES	25/08/10
SPECIFIC SEARCH OF CINAHL PLUS AND MEDLINE	13	INTERMEDIATE CARE CASE STUDIES HOSPITAL AT HOME OLDER PEOPLE	09/05/13

The next section on related disciplines explains how nursing has drawn from other knowledge bases. Previously mentioned in the theoretical framework is the need for this study to undertake a holistic approach in its data analysis to ensure all aspects of patient experiences in response to a health service change is uncovered. Also, it was mentioned that the intention of this study is to retain a patient focus. The patient participant group age range was above 65 years old, therefore this justifies a closer look at literature pertaining to this older adult group. In addition, the specific search strategy undertaken in August 2010 revealed an article by Wade (2004) who stated that intermediate care services are in an ideal position to tackle age discrimination and ensure fair access to services.

4.2 Related Disciplines

Nursing has drawn from other disciplines to strengthen its own knowledge base like science, medicine, psychology and philosophy. McCormack and Titchen (2001) believe added to its own theory and knowledge this has given them a holistic

approach to caring for the patient. A range of skills are needed in today's healthcare climate and inter-professional working is advocated. Even though a multi-disciplinary team may share knowledge, Baxter and Brumfitt (2008) believes distinct role boundaries remain because of the depth of knowledge of their individual profession.

The theoretical framework presented in chapter three enabled a brief explanation of the different elements of care that nursing can draw upon. Namely, disciplines of medicine concerning assessment of the physical body, sociology in respect of social support networks and assistance to achieve daily activities and lastly psychology where anxiety or stress is recognised and alleviated. It is not intended to further analyse all related disciplines but to focus upon those which is relevant to this study. Therefore, before specifically looking at the immediate discipline of intermediate care it is necessary to discuss what other literature has been found relating to this study.

This study is patient-focused so literature has been reviewed that is most relevant to the patient experience. The sample age range of patient participants is 72-89 years old, with a mean age of 80.5 years. Therefore, this group of older patients may face challenges that younger adults do not (Wade, 2004). They are likely to have physical and cognitive decline which impacts on their ability to self-care and their recovery rate from illness or injury (Hughes, 1995). Also, older adults are more likely to have multiple morbidities, polypharmacy and suffer social isolation (Nobili et al. 2011). Therefore, two themes that emerge from literature to be explored are that of ageing and loneliness because a lot of older adults live alone (Nobili et al. 2011). The two themes of ageing and loneliness have social and psychological consequences. Therefore, they link to the Comfort theory (Kolcaba, 2012) and the bio-psycho-social model (Engel, 1977), which underpin this study and is used for holistic data analysis.

4.2.1. Age Discrimination

Age discrimination is addressed in Standard 1 of the National Service Framework (NSF) for Older people (DH, 2001). This standard explains that older people should not be discriminated against in access to health and social care services and that all care received should be decided upon the basis of need, not age (DH, 2001). The evidence presented in the framework refers to the 1990's where it was found older

adults experienced health inequalities in access to treatment at coronary care units, palliative care and some domiciliary social care assistance (DH, 2001). However, this evidence is somewhat outdated now and the patient participant group in this study mostly felt they had fair access to health and social services in the chosen research locality.

This study discovers if the research sample population have experienced any age discrimination or if they perceive they are being positively discriminated against in being offered an alternative service. It also reveals from data any themes that emerge in relation to age. Hughes (1995) explains there are different theories on ageing such as the biological perspective, psychological and social gerontology. The biological perspective concerns the pathological degenerative process of the human body post-peak adulthood of 25 years of age (Hughes, 1995). The psychological perspective concentrates on the psychological decline in memory and inability to learn new skills, and the sociological perspective is largely characterised by disengagement theory where the individual gradually withdraws from society (Hughes, 1995).

Examination of the interview data collected in this study reveals if any theories of ageing emerge in the sample population's perceptions and beliefs. Already one can see the link between this aging theory and that of the theoretical framework chosen. Both concern the physical, social and psychological processes of human beings. It is these elements that are affected by age or injury or illness. Also this research is looking at an individual participant's experience of maintaining or regaining their former level of functioning. Thus, this should take into account prior abilities and realistic goals set by the staff of what is achievable for them in terms of comfort, functioning and self care ability.

A search strategy was constructed to identify the prevalence of older adult age discrimination since the 1990s. Cinahl Plus database was searched (08/05/2013) for any articles pertaining to this theme. The key words searched were 'age discrimination' in any article title. The search was limited to literature written in English language, full text available and articles published after 1990. The results

revealed 38 articles of which 20 were pertaining to employment law, so were not analysed. There were irrelevant articles on age discrimination against children, on hearing ability, genetic screening and clinical trials. This left nine articles that were directly related to older adult age discrimination in health service provision. Two out of the nine articles related to mental health service provision and one to breast cancer care treatment. One out of nine articles related directly to the NSF for Older people (DH, 2001).

It is necessary to review the relevant articles to ascertain what additional information has been discovered regarding age discrimination of older adults because this is the group that makes up the sample population. An opinion article written by Crome and Natarajan (2004) evaluates the NSF for Older People (DH, 2001). They view the framework in a positive light and emphasise that it is needed to stop under or over prescribing to the elderly and restricting access to certain medications via specialists (Crome and Natarajan, 2004). However, the author Crome (2004) has had several previous research trials funded by manufacturers of dementia drugs, and argues that age discrimination has caused delays in their availability to older adults suffering dementia in the NHS. Therefore, this could be negatively viewed as the author has a personal interest in ensuring that more dementia drugs are available on the market. However, it could be positively viewed that this author welcomes the framework (DH, 2001) due to the fact that it is helping older people have access to the drugs they need by rooting out age discrimination.

Collier (2005) argues that there exists age discrimination in mental health services for older adults. Collier (2005) cites several examples of how older adults are discriminated against by health policy assuming the biggest concern in older age is dementia and not depression, by using the word 'elderly' society generalises it as synonymous with high dependency levels and that mental health services see adults as 16-65 years old, so if you are outside this bracket you are 'elderly' and need some different kind of adult care. Collier (2005) criticises the NSF for Older People (DH, 2001) as it provides nothing for those with severe and enduring mental illness and says it is difficult to find any statistics for the adult over 65 years old with psychosis. This is a good article to highlight lack of services for older adults with mental health

problems and Collier (2005) recommends that mental health nurses must publish their findings as there is a gap in the available literature.

Blakemore (2009) supports Collier's (2005) findings of age discrimination existing in mental health services, stating older adults are still denied access to services such as out of hours and crisis resolution teams, also substance misuse services.

Blakemore (2009) sees the NSF for Older People (DH, 2001) as a missed opportunity for health organisations to commit to tackling this problem. However, Blakemore (2009) found out in the report, Equality in Later Life: A National Study of Older People's Mental Health Services (Care Quality Commission, 2009) that to eliminate age discrimination in mental health services in England would require an extra 24% increase in funding, which stood at £8.4 billion a year. This financial information may justify why age discrimination is not eradicated several years after the standard was published in the framework if health care funds are limited (DH, 2001).

Age discrimination against older adults is also present in breast cancer services according to Davis (2010). She cites research that was undertaken by Leonard et al (2010) that found women over 65 years of age were less likely to receive chemotherapy and radiotherapy compared to those aged 50 years and under, and those aged over 80 years were 40 times less likely to undergo surgery. Davis (2010) feels that minimum standards of care must be introduced for women aged over 65 years old who suffer breast cancer, as risk of this disease increases with age. No articles arose in the literature search on male cancers like prostate or testicular and age discrimination. It appears from this evidence that there are still health inequalities in relation to age and palliative care services existing in 2010, which the NSF for Older People (DH, 2001) had aimed to root out.

There are three general articles on age discrimination in the NHS with startling findings. One article by Scott (2000) quotes a Consultant in care of the older person saying elderly people are left to starve to death by way of involuntary euthanasia which the Police are investigating. However, Scott (2000) points out that this may have occurred due to ambiguous medical guidelines regarding the withdrawal of

artificial nutrition to those with poor prognosis or terminal illness being misinterpreted. Scott (2000) feels that the hospital experience for older adults can be disorientating and debilitating which further impairs their self-care ability. This is interesting for this study as the hospital patient group could feel disorientated and less able to care themselves in a different environment other than home.

The two other general articles state that age discrimination exists in access to services across the health service. They describe studies by the Kings Fund (2002) and Age Concern (2006) and call for legislation to end unfair access to treatment for older people. The remaining two articles relate the nurses' role in tackling age discrimination. Doherty (2009) calls for nurses to input into the delivery of the Equality Bill (2009) on their experiences of age discrimination against the elderly. The Equality Bill (2009) was devised to outlaw age discrimination against people over 18 years in the provision of services. Davis (2009) supports this saying nurses need to help eradicate age discrimination by practising on the principles of equality and diversity. The staff participant group in this study which encompasses nurses are asked in the interviews if they felt the patient was part of the decision-making process and if they felt any additional services were needed to meet the patients' needs.

It is apparent from the literature on age discrimination, which is relevant to examine due to the older adult population in this study that patients over the age of 65 years can find they have a decreased access to services that are available to younger adults. Some authors (Blakemore, 2009; Collier, 2005) have felt that the NSF for Older People (DH, 2001) has not been wholly successful due to lack of commitment and financial restraints. Through staff and patient participant questioning this study ascertains if age discrimination is present in intermediate care or if by offering an alternative type of service can be viewed as positive discrimination of older adults. No articles were found on age discrimination existing intermediate care, but Scott (2000) felt that elderly patients in hospital were vulnerable to age discrimination taking place. Therefore, this study will enlighten the reader as to whether the group of ten patients interviewed feel discriminated against due to their age.

4.2.2 Loneliness

From evidence on aging it is known that the older person can suffer social isolation (Nobili et al. 2011). This study will reveal if loneliness is a factor for the patient participants as it is analysing both social and psychological experiences of illness/injury. Murphy (2006) agrees that loneliness involves social and psychological aspects. Loneliness may be exacerbated by ill health if their physical function is impaired and they can no longer engage in society. Loneliness is defined as a feeling of psychological discomfort, an inability to increase the quantity and quality of relationships and can contribute to poor psychological and physical health with the elderly population, the disabled or those bereaved most at risk (ElSadr and Nouredine, 2009).

The psychological perception of loneliness may differ amongst home and hospital patients. Nobili et al. (2011) states that older adults living alone suffering economic difficulties complicates their use of healthcare services and following health promotion recommendations. This can be interpreted as an elderly person may not be able to afford public transport or taxi fares to hospital or GP appointments or to go out socialising. They may not be able to walk to the bus stop or to go shopping and carry heavy shopping bags home. If they live alone with little or no family support they may not have anyone to help them access services or maintain a healthy lifestyle.

Disengagement theory (Cumming & Henry, 1961) explains the older adult has contributed to society and does not want to become a burden on society so withdraws from it. The counter theory is that of Activity theory where it is believed that any loss of role, activities and relationships should be replaced with new ones to ensure well-being in old age (Powell, 2001). Disengagement theory can be criticised as it does not mention class. The more affluent participants would probably have afforded private help and to attend more social events or physical activities.

Picton (1991) argues that it is not axiomatic that old age equals a decline in social interactions and networks. The author states that it is the professional's responsibility to encourage engagement with society even if it takes a different form from when

they were younger, such as luncheon club or book club. Therefore, one cannot assume that if all the patient participants are elderly then they are lonely or that they are all socially active.

This study examines this theme further under the social and psychological headings in data analysis. Some patients have family visiting them in hospital and do not feel lonely. The patient group at home may feel isolated and not have any visitors. An immobilised limb can prevent activities (Handoll and Madhok, 2008), for example, going to the shops or day centre. What is apparent from the above evidence is that one cannot generalise that all older people are lonely and that not all older people will be unable to find or find resources to help themselves.

A search was made on Cinahl Plus database (08/05/2013) using the key word 'loneliness'. Limitations applied were to restrict to English language, full text available and to find articles that have published since 1950. However, the earliest article published that emerged from the search was 1981, and the reason for this is unknown. 131 articles were found. Articles were discounted that concerned loneliness experienced in prison, psychiatric patients, children, HIV, substance misuse, sexual offenders, Iranian people, during war time captivity, being homosexual, in death, bereavement, elder abuse, cancer and nursing homes. Therefore, it was necessary to refine the search specifically to loneliness experienced by older people, so the search terms 'loneliness' and 'older people' was used which produced 17 results. After removal of duplicates and articles concerning cognitive problems or loss in childhood affecting them in later life, six were left to review.

Both search results were compared and the first search group produced six results that were relevant to loneliness in older adults, but these did not appear in the second search result group. Therefore, it was decided to review them also due to their relevancy, giving a total of 12 articles to be examined. From the first search on 'loneliness' an article was found by Pettigrew and Roberts (2007) who undertook qualitative research into how to address loneliness in later life. They interviewed 19 Australians aged 65 years and over with an average age of 79 years. 16

interviewees lived alone and the majority were women. The negative aspect of this study is that the participants were recruited via a care agency and retirement village managers. Therefore, they could have subjectively chosen those whom they thought would be suitable to be interviewed rather than the researchers randomly selecting a representative sample of the older population. The authors acknowledge this weakness.

According to Pettigrew and Roberts (2008) interviewees describe loneliness as an inevitable part of aging due to social isolation caused by declining mobility, senses, passing away of friends and family members too busy to spend time with them. However, they point out that some participants felt they had control over their loneliness and were proactive in activities like gardening, reading and food and beverage rituals. Pettigrew and Roberts' (2008) recommendations from their findings are to encourage self management of loneliness, to facilitate their activities such as providing senior-friendly gardening equipment, books, communal pets and regular contact with friends or relatives. This links to this study to discover if the patient participant group experiencing care at home or hospital undertake such activities under the social analysis category.

Eshbaugh (2009) conducted qualitative research to look at ways older women who live alone cope with loneliness. Eshbaugh (2009) had hypothesised that friends could predict degree of loneliness for those women who did not have family living close by, but this was disproven with the results. The findings showed that even when close family members lived nearby it did not mean they were supportive, so close friends were more important to the women than the proximity of family. Eshbaugh (2009) acknowledges a weakness of this study in the small sample size of 53 women. Also, this study offered a gift voucher for \$15 to participate, so a proportion of women would have been omitted who would not be influenced by a gift to participate.

Stanley et al. (2010) undertook focus group research into loneliness of older Australians. The authors feel they recruited a diverse group of 60 participants from four large service providers. Their findings showed five interrelated aspects of

loneliness, namely, being private, relational, re-adjustment, temporal and connectedness. Stanley et al. (2010) found from the focus groups a stigma existed of admitting loneliness which makes it difficult to identify individuals who need help. Perhaps some participants in this research study will not admit they are lonely and ethically they should volunteer the information rather than be scrutinised over their social inclusion or isolation. Stanley et al. (2010) acknowledge a weakness of their study is that they did not include participants from the more remote rural areas, so further exploration of this population's experiences would be warranted.

Theeke (2010) used a much bigger sample size to examine for loneliness of 13,812 older adults from the US Health and Retirement Study (National Institute on Aging, 2007). Overall prevalence of loneliness was 16%, with those who lived alone with poor health reporting more loneliness experienced (Theeke, 2010). The lonely group of individuals took less exercise, smoked more tobacco, had less alcohol consumption, a higher number of chronic illnesses and depression rates than those who did not report loneliness (Theeke, 2010). This is an interesting link between factors such as less exercise and poorer health and the likelihood of loneliness experienced which could be evident in this study's sample population.

Graneheim and Lundman (2010) utilised the Umea 85+ Project to form a partial study on the effects of loneliness experienced by people aged above 85 years. This is the only study reviewed which not only reveals the negative aspects of loneliness, but the positive effects as well. Their research discovered that the degree of negativity felt depended on the individual person's inner strength, outlook on life and death and being aware of one's limitations. Graneheim and Lundman (2010) bring a positive dimension to loneliness stating it can be opportunity for independence in decision-making, to reside in peaceful surroundings, can preserve identity and obtain a broader perspective on life. The lesson learnt here is that one cannot generalise that if an elderly person lives alone with poor health in this study's sample population that they are lonely or if they are that they have not turned this into a positive experience.

A research article was found that related to hospital patients and loneliness which is relevant to the hospital group of patients in this study. Molloy et al. (2010) examined if loneliness was experienced greater by older adults upon emergency admission to hospital or planned admission. A weakness of the study is that it relied on retrospective recall of hospital admissions over the last year. A strength of this study is that it found that covariates such as depression and degree of social support did not influence the occurrence of loneliness when an emergency admission had to take place. However, it found that lonely individuals did have more emergency hospital admissions and less loneliness was experienced with planned rather than emergency admissions (Molloy et al. 2010). This is relevant to all the patient participants in this research study as they all would have attended A & E as an emergency admission due to an unforeseen injury. Thus, emergency care can possibly exacerbate loneliness, rather than planning for an expected hospital admission.

One of the six articles from the second literature search claims that the effects of loneliness can lead to premature death in the older adult (Skingley, 2013). Skingley (2013) believes that community nurses are in an ideal position to help older people who feel lonely by interventions such as befriending, mentoring, home visiting, telephone support, social support and gatekeepers such as residential wardens help link vulnerable older people to activities or local volunteer services. Community engagement in this issue, the exercise of mapping out local service provision and television programmes are advocated and discussed by this author.

Murphy (2006) believes loneliness is a challenge for nurses and how to recognise and alleviate it should be part of nurse education. Nurses need to emphasise the benefits of physical exercise and gardening (Murphy, 2006). However, the weakness of promoting physical exercise is that some older people with mobility problems may not be engage in these activities.

Steed et al. (2007) conducted a demographic study of loneliness in older people in Australia. The strength of this study is that they randomly recruited from electoral roles an equal number of men and women. Their findings found seven percent of the

353 sample population suffered severe loneliness but dependent on the measurement scale used, women were found to be lonelier than men (Steed et al. 2007). The authors speculate that men may feel more reluctant to admit loneliness and it had more of a lonely effect on women to not have close relationships with family or friends.

Tikkainen and Heikkinen (2004) found a link between depression and loneliness in a Finnish sample of older people from a five year follow up questionnaire. The authors point to a weakness of their study being a small sample size (133 at follow-up) and only a small portion of these felt lonely. Tikkainen and Heikkinen (2004) also feel there is a stigma attached to admitting loneliness, so our sample population may not admit to feel lonely. Tikkainen and Heikkinen (2004) concur with previous evidence that loneliness appears more prevalent in women, but also that those suffering loneliness and resultant depressive symptoms had a lower level of perceived emotional togetherness in social interaction. However, the authors inform of the different types of loneliness in that someone can be socially lonely or emotionally lonely or both.

Routasalo et al. (2008) undertook a randomised control trial into the effects of psychosocial group rehabilitation on lonely older people. The authors found the UCLA Loneliness Scale used to measure at three monthly intervals over a year period showed no difference in loneliness between the control and intervention group. The authors question the reliability of this tool or whether it was because of group discussions taking place that participants were more willing to admit loneliness as it had been brought to the forefront of their mind. Routasalo et al. (2008) found positive results that the intervention group had made more friends, were more involved in social activities and their well-being scores were higher at one year follow-up. Therefore, these authors conclude that group social interaction and activities in the form of psychosocial rehabilitation was beneficial to older adults' well-being.

Some of the authors on Routasalo et al. (2008) research later published a more detailed analysis of what psychosocial interventions were involved in the group

rehabilitation. Savikko et al. (2009) explain there were three different group interventions of art, group exercises and therapeutic writing. Results showed that 95% felt their loneliness alleviated during the intervention sessions and all three groups enjoyed a raised self-esteem and engagement in their communities (Savikko et al. 2009). This study fails to mention how the wider community can fund such group therapy sessions; also in this research participants were given free meals and drinks. The intermediate care professional would have to map out what services were available in their community and attempt to engage an older lonely person in these, such as day centres, if no funding was available to set up group therapy sessions.

The two related disciplines discussed has given the opportunity for the reader to familiarise themselves with the patient group in this research study. The sample population studied consists of all older adults and this age group experience challenges to their health and access to health services that younger adults do not. Therefore, it has been necessary to discuss two themes of age discrimination and loneliness. These themes have allowed a picture to emerge of potential experiences the research participant may divulge in interviews. Also, none of the research articles found on these two themes were specifically about intermediate care, therefore, it is needed to uncover what difficulties if any this patient participant group experiences with intermediate health service provision.

4.3 Immediate Discipline

In summary so far we have learnt about the background to this research study in the form of the history of health service provision and policy literature, next a concept analysis on intermediate care and a theoretical framework was presented, lastly related disciplines have been discussed with particular reference to the participant group characteristics of containing older people and the challenges they may face. It is now necessary to focus in on intermediate care and ascertain if similar case study research exists.

Before attempting a database search, a general search of literature was undertaken via Google on case studies of care at home as opposed hospitals in August, 2010.

This provided a basis upon which to build knowledge. Next a search strategy was formulated and Ovid Medline searched (25/08/2010). Due to length of this study and writing up its findings a mop up repeat search for case studies and intermediate care was undertaken (09/05/2013) to ensure data collected was as up-to-date as possible. Therefore, results of these searches will be presented in chronological order.

4.3.1 General Literature Search

A general literature search for other case studies on care at home as opposed to hospital via Google search engine (25/08/2010) mostly revealed research on palliative patients and those with chronic illness. This general search was taken before composing a specific search strategy out of interest as to what articles would emerge from an internet search. With those not directly relevant discounted, four articles were worthy of reviewing as related to this study.

Firstly, Loonan et al. (1991) found if patients were treated at home it would not necessarily involve solely nursing care which could be expensive. They found care at home encompassed unqualified nurses in the form of care givers to help with daily activities and other professionals such as physiotherapists and occupational therapists. This evidence suggests quality care can be delivered at home at less cost than if the person remained in hospital with 24 hour nurse care. Home care in this article stresses the importance of carers able to give personal care and help with everyday activities. Therefore, it indicates what type of professional is needed to deliver care at home and dismisses any misconception that this care is solely delivered by a qualified nurse.

Bowles et al. (2002) found the need to improve methods of identifying those suitable for home care on discharge. They discovered unmet discharge needs and those sent home without support were at higher risk of admission. This brings into question professionals' assessment decisions on what patients suit the criteria for help at home and the need to ensure the criteria is effective identifying suitable patients. Therefore, in examining if the Early Response Service's criteria are identifying the correct people for home care in this research study, the ethics of making the best

decision for the patients' recovery will emerge and hopefully a re-admission to hospital will be avoided. Any unmet discharge needs may emerge from the data and highlight where improvements in terms resources such as staffing and equipment are needed to help care for more people at home.

Intermediate care in a Welsh locality produced research regarding a case study of an elderly man receiving care at home which avoided a hospital admission (Davies, 2009). They used this example to illustrate the benefits of their service where the Consultant performs home visits. However, their service receives GP referrals as opposed A & E referrals. This is an area the Early Response Team can expand into covering such as referrals from GPs to prevent the patient attending A & E in the first place. Inter-professional working and effective communication becomes important in determining if the patient can be cared for at home. The patients' wishes must be taken into account, as well as available resources.

Thomas and Lambert (2008) performed an ethnographic study to examine the perceptions of staff referring to community-based Intermediate care. They found themes of shared responsibility, recognition of conflict areas, co-ordinating services and the implications for nursing are discussed. It is clear that a lot of work and effective communication between professionals takes place to adequately care for a person at home instead of at hospital. This research will not focus on the wider networks between services, but will gain referrers' opinions on the intermediate care service the patients received.

4.3.2 Specific Literature Search

Search Strategy 2010

A more specific literature search took place on the 25th August 2010 using Ovid Medline. A search strategy was formulated to search for the key words like 'intermediate care' which produced 3937 results. A search for 'case studies' produced 517785 results. By combining both terms 181 results were found. Removing duplicates and placing a limit of full text available produced 44 results. 36 out of the 44 articles were deemed irrelevant as they pertained to psychiatric in-patient care, colorectal resection, high levels of cortisol in critical care, pelvic floor

dysfunction, oncology and other areas of care not pertaining to research within intermediate care. The articles remaining were found to be directly relevant to the research as they described research on intermediate care or transitional care from hospitals.

TABLE 5 – SUMMARY OF A SEARCH PROCESS

KEY WORDS SEARCHED ON OVID MEDLINE 2010	NUMBER PRODUCED BY COMBINING	REMOVING DUPLICATES/ FULLTEXT AVAILABLE
INTERMEDIATE CARE	3937	
CASE STUDY	517785	
	= 181	44-36 = 8

Baumann et al. (2007) used qualitative research to interview health staff to determine service elements which contributed to the avoidance of delayed discharges. The authors found there were three fundamental themes which cause delays, namely health and social care capacity issues, internal hospital inefficiencies and inter-agency issues. These themes presented as communication problems within the multi-disciplinary team and attendance problems at meetings along with complex access arrangements to intermediate care.

Baumann et al. (2007) explain that in 2002, the House of Commons Select Committee on Health, supported government policy for rapid development of intermediate care with a range of health and social services to reduce unnecessary admissions to hospital and to rehabilitate people after a hospital stay. They also state that trusts were advised at this time to make patients aware early on that after their acute phase of care was over; they had no right to stay in hospital but could choose their post-discharge care. Their results state that the Community Care Delayed Discharges Act of 2003 had an impact on decreasing delays due to the reimbursement scheme, but also the use of an estimated discharge date and designated discharge teams to co-ordinate health and social care (Baumann et al. 2007).

This research is relevant background information as it highlights the delayed discharge problems and state of intermediate care before and after national policy

was introduced. Therefore, it leads onto in 2009 the setting up the Early Response Service in order to achieve better hospital bed utilisation and better care post-discharge delivered in a prompt manner. Crotty et al. (2005) undertook a randomised control trial regarding transitional care for elderly people awaiting a long term care bed. They concluded that moving hospital patients who were waiting for a long term residential bed into a transitional facility with on-going therapy had no adverse effects to their health. It removes the stigma of being a 'bed blocker' and provides a useful care alternative.

This trial is useful as it tells us hospital staff have another option other than choosing a step down bed at a community rehabilitation hospital in order to free up acute hospital beds, if patients are well enough for transfer. This is supported by Fleming et al. (2004) who conducted a randomised control trial of care home rehabilitation to reduce long term institutionalisation. They found the service did not reduce institutionalisation, but did divert patients from hospital to social services sector without any major effects on their activity levels or well-being.

Kaambwa et al. (2008) conducted research on the costs and health outcomes of intermediate care in five case study sites. Their results are directly relevant to this research and can give an insight on what data may emerge from the research findings. They examined 2253 episodes of intermediate care where 82% were non-residential, 55% of the sample involved admission avoidance services and 45% early discharge services. The median age of their sample was 81 years and 70% were female. The mean duration of intermediate care was 29.5 days with a mean cost £1200 per patient.

Kaambwa et al. (2008) found that there were greater health gains associated with intermediate care as scored on the Barthel index and Euroqol EQ-5D. However, they did find that 47% of patients were inappropriately admitted to intermediate care; that the alternative would be a hospital bed or residential care. This can support the view that some intermediate care services are not being targeted at those who most need it. The authors point out that these patients still benefitted from the intermediate care services in terms of health and functional ability. Therefore, this adds weight to one

of the objectives in this research to interview staff also, to find out what types of patients can be helped in the community to prevent an unnecessary or inappropriate admission to hospital. This will help give clarity to the criteria for admission to the Early Response Service.

Nancarrow (2007) performed 26 staff interviews on two case study intermediate care sites. She found participants reported a high level of job satisfaction because of the enabling philosophy of care, increased autonomy, the setting and the teams in which they worked. The background literature to her research had suggested a de-skilling of staff and that intermediate care is poorly understood. She advocates the rotation of hospital and community staff through intermediate care so a better understanding and awareness is reached about this 'middle' area of care. Also, that there is a need to improve professional growth opportunities through the use of Consultant posts and the area as a specialism.

Nancarrow (2007) explains that skills were used in a different way with the enhancement of some and restriction of others. The Early Response Service has a Consultant in place who supervises nurses who are undergoing the masters' degree in advanced practice, so the Early Response Service is addressing professional growth issues. Four therapy staff posts are rotational therefore health workers are gaining an awareness of intermediate care. It is hoped this research will help intermediate care gain a better understanding across all disciplines.

Nancarrow (2004) also published research regarding the role overlap of professionals in intermediate care. It is necessary whoever assesses the patient in intermediate Care to have an understanding of other professionals' roles in order to meet the patients' needs i.e. an Early Response Nurse will need to recognise that the skills of an occupational therapist is needed for a raised toilet seat and to raise an armchair, he/she only knows this if she asks questions about functional ability in relation to their illness. Nancarrow (2004) found that role overlap in intermediate care only serves to enhance professional confidence in their area of expertise whilst optimising patient care and optimising limited staff resources in an interprofessional working environment. It is hoped this research will highlight this theme of the

professional who makes decisions regarding a patients' care will have knowledge of the holistic needs of the patient and which member of the health team specialist skills are needed.

Brooks (2002) evaluated the first year of a rapid assessment service in Leicester, which is similar to the Early Response Service on a smaller scale. The scheme only operated Monday to Friday and only have one half time equivalent social support worker. Their aim was to prevent unnecessary admission to hospital and they had a four hour response time. By way of case study design, analysis on discharge summaries and patient diaries took place. Brooks (2002) found the common reasons for referral were falls prevention and assistance with activities of living. The key themes identified were partnership working between health and social care, promotion of independence, relief of carers, effective use of professionals' time and satisfaction with the service.

It has been interesting to see what themes emerge in this research and a similarity was found to Brooks' (2002) study where the most common reason for referral to Early Response Service was falls. Brooks (2002) believes for similar schemes to be set up elsewhere issues of engaging the wider health and social community, health economics and long-term impact on health and social services need to be addressed. What the future of intermediate care will be like needs to be anticipated by fund holders in order to effectively resource this expanding service as an alternative to hospital admissions. Regen et al. (2008) conducted qualitative case study research and found the major challenges to Intermediate care were health and social care needing to work together more in a whole system approach and to promote intermediate care among doctors to ensure their support and use of the service.

Wade (2004) considers team working and effective decision-making by multi-disciplinary professionals as essential to the success of intermediate care. Wade (2004) also advocates care pathways for intermediate care so the journey of patients can be clarified and expectations of care met. Wade (2004) believes intermediate

care services are in an ideal position to tackle any age discrimination against elderly people to ensure fair access to services.

Search Strategy 2013

A mop up approach was taken to ascertain any further articles concerning intermediate care. The databases Cinahl Plus with Full Text and Medline was searched (09/05/2013). Limiters to search was the date from 1950, full text available and in the English language. The first search term was 'intermediate care' to be found in any article title, however this produced zero results. With the added use of SmartText searching 131,147 results were displayed. Next a search for 'case studies' was undertaken which produced 280 results. By combining both terms 68 articles were found.

Again there were a lot of irrelevant articles regarding palliative care and psychiatric care. Therefore, a different approach was added to search under the term 'hospital at home' (3,762 results) and 'case studies' (280) which produced 16,066 articles. This was too much to scan through so an additional term was added of 'older people' and 25 results appeared. However, by combining this with case studies zero results were found. Therefore, it was decided to examine the first 68 articles found and the second lot of 25 results for relevancy. The following is the information found from this search in 2013 where 13 articles were worthy of review.

The first article found by Donnelly and Dempster (1999) was an evaluation of a home from hospital scheme where 75 patients were interviewed after receiving early discharge from hospital into a care at home domiciliary scheme. A similarity with this study was found where the patient group was made up of mostly those who suffered fractures. One can infer then that this is an easier group of patients who can receive care at home as opposed those with complex needs. Often people with a fracture have one limb immobilised for several weeks (Handoll and Madhok, 2008). Therefore if they were coping prior to this, with rehabilitation and assistance to compensate for lack of use of one limb they can be successfully treated at home. Donnelly and Dempster (1999) found this scheme an effective service based on patient feedback and helped facilitate discharge.

The earliest research article found was by Warren (1957) who interviewed 12 patients to ascertain how they got on after discharge from hospital in their home environment. Warren (1957) found that patients had difficulty in their environment concerning narrow doorways, poorly arranged kitchens, economy-dictated bathroom planning and a multitude of physical obstacles that determined the limits of independence, self-care and self-help of the older person. This is important as it informs of issues that may arise under the 'environment' heading in this study. It is evidence that environmental issues may hinder recovery and the goal of independence.

A systematic review was found by Forster and Young (2010) which should present reliable data. They examined seven randomised control trials comparing home-based rehabilitation to that of day hospital care. The review was conducted because the authors felt that day hospitals was the first kind of Intermediate care in preventing hospital admissions, but they questioned its cost effectiveness due to ambulance transport needed, facility overheads and taking the patient out of their own environment. The alternative was home-based care to deliver rehabilitation by a multi-disciplinary team. The results found that home-based care was more resource efficient, there was opportunity to involve the family/carer and was more patient centred (Forster and Young, 2010). The authors state the weakness of the review is that the trials would need much larger sample populations therefore they remain neutral in saying that home-based care is statistically better than day hospital as they both achieve similar patient outcomes.

A literature review of 44 research-based publications by Coffey (2006) reveals recommendations regarding issues with discharging patients from hospital to community-based care. Coffey (2006) found that communication was the key to success and recommends that further research is needed in not just using readmission rates as a measure of failed discharge home. She also states that care in the community needs to be approached as holistic in nature with multi-disciplinary involvement and there needs to be improvements in the networks of providers. The weakness of this study is that she mixed qualitative with quantitative results which can cause methodological integration problems. Nonetheless one can relate its

recommendations to this study as she advocates care that is holistic in nature with multi-disciplinary involvement. Also, the Early Response Service has to correctly identify those suitable for home care or a readmission may occur.

Holland et al. (2005) conducted a randomised control trial of 872 patients over 80 years old with an intervention of two pharmacist follow-up visits in the community to ascertain if this prevented re-admission. However, their findings were counter-intuitive with a higher rate of re-admissions in the intervention group. Holland et al. (2005) state that there was slightly a decrease in death rates in the intervention group as opposed the control group, but they had thought a medication review would prevent re-admission as often medication problems can cause an admission to hospital in the elderly.

They have no explanation as to why their intervention did not work, however one can speculate that this group of elderly people often have co-morbidities which make them vulnerable to admission. This study is relevant for the Intermediate care doctors as often they are prescribing medication or reducing unnecessary medication. Holland et al. (2005) recommend any further medication reviews in the community to concentrate on quality of life outcomes rather than reducing re-admission rates.

A systematic review was found that also used readmission rates as an outcome measure. Linertova et al. (2011) compared clinical trials of hospital and home-based interventions. They found that home-based interventions were more likely to reduce readmission rates, but that most of the interventions found did not have any effect on readmission rates. This supports the evidence presented by Holland et al. (2005) who advocate using a different measure other than readmission rates. Linertova et al. (2011) also had difficulty with comparable data as some studies undertook their follow-up at different times or there were varying length of interventions. The Early Response Service in their monthly audits did collate quantitative data on the number of readmissions, but it appears from the evidence it is a poor indicator of quality of care intervention and a quality of life scale may be a better measure. However, this

research study focuses on patients' experiences towards a successful recovery and not quality of life specifically.

A journal article found in *Hospice Management Advisor* (Thompson, 2011) revealed a hospital's success in a bridging program for recently discharged patients with care and advice provided at home along with access to out-patient facilities. It states there was a reduction of 41% in emergency admissions and 27% in in-patient admissions compared to the three months prior of joining the programme. Even though this study's components are not broken down to analyse it can be acknowledged that a scheme to provide care at home has in one hospital's opinion reduced the pressures on its bed usage. This is an aim of intermediate care to relieve pressures on the secondary sector as evidenced in the concept analysis, chapter two. This article is contradictory to the two before it. It appears a more reliable argument is that a hospital admission was prevented from home care, rather than a readmission was prevented after the intervention has taken place.

A similar article was found by McCain (2012) which hails the success of a two year project in New Mexico of hospital at home regarding patients who suffer diseases such as chronic obstructive pulmonary disease and heart failure. McCain (2012) acknowledges that hospital at home is not for everyone but for those who did not need highly specialised equipment, they benefitted from person-centred treatment at home and it saved 19% in costs compared to in-patient traditional care. The relevancy of this is that it suggests a cost saving to have care at home as opposed hospital and it also may inform future practices for Intermediate care. McCain (2012) states that some of the resources used at home included portable diagnostic equipment, telehealth and video link to the health care team. Therefore, this could be areas the Early Response Service expands into if they have more acute patients at home with the aide of modern technology.

Utens et al. (2013) in a randomised control trial concerning early discharge for patients suffering chronic obstructive pulmonary disease found no difference in overall patient satisfaction rates with care at home or staying in hospital longer. The home care group as they left hospital earlier had lower satisfaction rates for

managing at night and for undertaking daily activities (Utens et al. 2013). This is probably because in hospital there are staff around to help you at night and help with daily tasks of washing, dressing or cooking. It is not stated that the intervention group received any help in terms of social support at home other than nursing support regarding their medical condition up until day seven and telephone access to the ward (Utens, 2013).

One can infer from this that even though Utens et al (2013) claim that patients prefer their care at home, their study reveals weaknesses in the programme of care at home. It is often daily tasks the patient needs help with completing during an exacerbation of illness, and it appears this social support was missing and satisfaction levels may have been more if this assistance was provided. The Early Response Service not only provides nursing and medical access, but the social support that is needed by patients at home in order to help regain independence.

Hallberg and Kristensson (2004) reviewed 29 papers regarding care at home of elderly people. These authors acknowledge an increasing emphasis for patients to receive care at home and feel case management approaches need to have preventative approaches to postpone functional impairments of older people. Their review of case studies on care at home found that the family or informal care givers were often left out of health care processes at home and that few case management strategies included risk assessment of falls, social activities, medications and disease management (Hallberg and Kristensson, 2004).

Hallberg and Kristensson (2004) advocate a rehabilitative approach where the nurse plays a key role and care appeared better when based on a comprehensive geriatric assessment. A weakness of this study is that they omitted studies that focused on specific diseases such as heart failure or pulmonary disease. However, the authors justified this as elderly people often have several chronic problems and complex needs. Therefore, the quality of case management from, for example, specialist nurses trained in specific diseases have been left out of this study and may have shown better more targeted interventions and outcomes. The relevancy of this article

to this study is showing the strengths and weaknesses of care at home and how a case management approach including preventative strategies is beneficial.

A study by Williams (2004) has been included in the literature review because it concerns the meaning of the home environment. Unfortunately the two case studies examined were of palliative patients, but it is useful to pick out the meaning of the home environment for the patients and their families. Williams refers to the Home Model in Home Healthcare Practice (HHMHHCP) by Roush and Cox (2000) where the term home has dimensions of home as familiar (comfort and ease), centre (base of everyday life) and protector (privacy and dignity). One can see that home as familiar incorporates comfort and this study's theoretical framework incorporates Comfort Theory (Kolcaba, 2012) as stated in chapter three.

Williams (2004) through analysing transcripts of interviews with patients and families, advocates adding another dimension of home as locator. This encompasses socioeconomic status and community integration. Thus, a holistic approach to the environment of home has emerged. This is relevant to this study as there will be factors underlying the patients' willingness to have care at home such as comfort, privacy and social network offset against their ability to cope with an injury at home without the 24 hour care they would receive in hospital.

Hyde et al. (2000) conducted a systematic review of randomised control trials of facilitated discharge from hospital to home with supported care at home. They caution of interpretation of their results as bias was found, but conclude with certainty there more patients remained at home at six and twelve months intervals when they had supported care. Hyde et al. (2000) state there was no rigorous data on functional status and patient and carer satisfaction. Therefore, there appears a gap on studies regarding care at home and these factors. This study will enquire about patient satisfaction with the care they receive at home and hospital and has a holistic approach of analysing data with the four main themes of physical, psychological, social and environmental. In addition to this the two themes of age discrimination and loneliness will be enquired about as these are relevant to the group of older participants.

It is not possible to predict the future of intermediate care accurately, however speculations can be made from evidence that exists today, for example, an article found by Dewsburys (2012) explores not only telecare, where technological devices such as sensors and telephone assistance are provided in a patients' home, but telehealth, where people with chronic conditions such as hypertension, diabetes, pulmonary disease can electronically monitor their vital signs and send this information to be interpreted by health professionals. Telecare and telehealth could be complimentary to the services already provided by the Early Response Service. This could enable more safety at home over a 24 hour period and monitoring of disease states, for example, if a patient had a fall from low blood pressure and medication was changed, the machine could take their blood pressure and send results to the intermediate care doctor to ensure safe monitoring.

4.4 Summary

In summary, from the literature found on age discrimination it has been learnt that there are different theories on ageing that concern the physical, psychological and social processes (Hughes, 1995) which are the same subject headings as three of the themes of the data analysis. Important issues regarding age discrimination have been found such as medication availability (Crome and Natarajan, 2004), mental health service provision (Blakemore, 2009: Collier, 2005), breast cancer services (Davis, 2010), poor prognosis and nutritional withdrawal, disorientation and lack of self-care ability in hospital (Scott, 2000). Also, unfair access to treatment (Kings Fund, 2002: Age Concern, 2006), and the nurses' role in tackling age discrimination on the principles of equality and diversity (Davies, 2009: Doherty, 2009). No studies were found examining age discrimination in intermediate care. This research study examines if age discrimination exists in the services provided at hospital or home. In summary the literature on loneliness related to its social and psychological effects (Murphy, 2006), which are two of the theme subject headings that will be used in the data analysis. Pettigrew and Roberts' (2008) study revealed that participants saw it as an inevitable part of the ageing process, but they had some control over it.

Eshbaugh's (2009) research reveals that close friends were important to alleviate loneliness and that having family live close did not necessarily reduce the loneliness

felt by older people. Stanley et al. (2010) found there was a stigma with older people admitting they were lonely and Theeke (2010) along with Tikkainen and Heikkinen (2004) found that loneliness can be linked to depression. Graneheim and Lindman's (2010) study found that loneliness can be turned into a positive experience promoting independence and a peaceful environment. Molley et al. (2010) found that older people were lonelier if a hospital admission was an emergency rather than if it was planned.

Skingley (2013) went as far as to claim that loneliness is linked to premature death. Murphy (2006) found that nurses can help alleviate loneliness by promoting exercise and gardening. Steed et al. (2007) found that women suffered more loneliness than men. Routasalo et al. (2008) and Savikko et al. (2009) stated the benefits of group therapy using psychosocial interventions to combat loneliness in older people. This study will reveal if any of the patients receiving care at home and hospital suffered loneliness, what were the reasons for this and if it is more prevalent in the hospital or home group.

In summary the general literature revealed themes such as care at home does not just involve qualified nurses and carers are a cost effective resource (Loonan et al. 1991). There can be unmet needs on discharge which can risk readmission to hospital (Bowles et al. 2002). The importance of the intermediate care Consultant's role (Davies, 2009) was found and the perceptions of staff referrers regarding effective communication between professionals and services (Thomas and Lambert, 2008). From this evidence, the research study needs to reveal how effective home care is by the Early Response service that all needs are being met, that a multi-disciplinary team is involved and find out if any service issues arise regarding effectiveness of care delivery.

The specific literature search (2010) revealed evidence relating to intermediate care that is important to this study. Baumann et al. (2003) explored the problem of delayed discharges and how these can be alleviated. Fleming et al (2004) discovered that the transition from hospital to social services sector had no major effect on activity or well-being levels, but it did not reduce institutionalisation.

Kaambwa et al. (2008) explored costs and health outcomes of intermediate care but found there were inappropriate admissions to its service. Nancarrow (2004, 2007) discussed the high level of job satisfaction by Intermediate care workers and role overlap. Brooks (2002) revealed the common reasons for referral to intermediate care such as falls and assistance with activities of living. Regen et al. (2008) presented the challenges to intermediate care which were health and social services working together in whole system approach and Wade (2004) looked at team working and decision making by the multi-disciplinary team to ensure success of the service. This study will explore the impact of intermediate care in pulling patients out of hospital to receive care at home and the importance of the multi-disciplinary team in doing this.

To summarise the second, more recent literature search (2013) and its findings; an article was found by Donnelly and Dempster (1999) who stated the most success with home health care is achieved with patients who have suffered fractures. This is a similarity with the type of patient the Early Response Service helps that the majority of patients have suffered fractures. The earliest article found by Warren (1957) discussed the difficulties patients had coping in the home environment like narrow doorways, and the most recent article found by Utens et al. (2013) found home patients can have difficulties managing at night and with daily activities. Williams (2004) explored the meanings of the home environment to patients. Therefore, to look at the aspect of the environment is important in this research.

Forster and Young (2010) compared home health care to that of a day hospital and found home care was more resource effective. Linertova et al. (2011) compared home health care with hospital based interventions and found home based interventions had a greater impact on re-admission rates at three month follow-up. Coffey (2006) examined issues regarding discharging patients to the community and advocated holistic care and effective networks between services. Holland et al. (2005) found that a pharmacist's interventions at home did not reduce re-admission rates, but improved quality of life. Thompson (2011) and McCain (2012) found that hospital at home programmes were successful in reducing hospital admissions.

Hallberg and Kristensson's (2004) research advocated that the family should be involved in the home care plan and tasks such as risk assessments on falls completed. Hyde et al. (2000) examined a facilitated discharge to care at home scheme and found it reduced re-admission rates. Dewsbury (2012) advised on the technological advances of the future of care at home with telecare and telehealth.

The literature review and summary above has not only given a background to this research study, but helped formulate questions to be answered. What is not known is how some of these aspects discussed affect patients treated by the Early Response Service within intermediate care. Even though health at home studies were found they were not identical to the system in the place in the chosen research locality. Also, factors missing from hospital at home programmes are present in intermediate care such as the multi-disciplinary team existing, family or carers are involved in care planning, falls assessments are completed and also medication reviews are undertaken. Therefore, from this study's results more rich data will be gained to add to this body of knowledge.

The results from the research data will inform with absolute certainty whether intermediate care is providing a successful alternative to hospital care. The results from the data analysis will yield new knowledge where a probable link or outcome has been found that was not known before. Themes that were found in the literature review like age discrimination and loneliness are searched for and examined, within the social and psychological headings of data analysis. The four themes of holistic care of physical, psychological, social and environment aspects have been derived from evidence in chapters one, two and three and their relevancy to this research justified. The discussion and concluding chapters in this study will reveal how the results of examining specific case studies relate back to the wider system of the NHS.

4.5 Conclusion

The literature review has found two new issues of age discrimination and loneliness that warrant searching for as themes in the data analysis. They are important as the literature has shown these are particular problems that older people may face and

this study concerns mostly older people. Also, the theme of age discrimination was explored in the document that first introduced a standard to intermediate care, namely the National Service Framework for Older People (DH, 2001).

The rest of the literature review encompassed a general search via Google search engine in August 2010, a specific search strategy undertaken in August 2010 and an additional specific search strategy undertaken in May 2013. Similar research studies to this one have been found and reviewed with relevant findings presented.

However, this literature review is by no means exhaustive and there exists different locality information on the successes of each region's intermediate care services that have not been accessed or are not published.

Out of the 46 articles reviewed, none were an exact replica of this research study. Therefore this study can be interpreted as innovative in its undertaking to examine this area of care which can complement and more importantly add to the body of knowledge that already exists. Due to its infancy in intermediate care teams grouping together and pooling resources as a community resource team only in recent years has a body of research evidence emerged that has both quantity and quality to examine. However, from the articles found it can be seen that this type of rapid intervention team in providing care at home does exist in other areas such as palliative care. The aim of producing a quality outcome for patients in alternative settings to save on hospital admissions is also evident. Therefore, the research results will be topical in light of the recent focuses in health care to move care to the community (WAG, 2005). Next it is necessary to present the methodology of how the research study was conducted based on what has been learnt so far.

CHAPTER 5

METHODOLOGY

5. METHODOLOGY

5.1 Introduction

This chapter will address the methodological and theoretical considerations of the study. This study was not deemed to be a service evaluation by the local NHS Research and Development Department. The qualitative evidence may produce new theories and new knowledge may emerge. However, the policy shifts described in chapters one and two that propose intermediate care can provide a successful alternative to hospital care is being explored. What is known from chapter one is that intermediate care has come into being to relieve pressures on both primary and secondary care. What is not known is the effectiveness of this in the research locality from a qualitative perspective. All that exists quantitatively is the number of bed days saved in monthly audits performed by the team.

The new intermediate care initiative in the research locality has been investigated from patients' points of view as compared to traditional care in hospital. In order to gain the patients' perspective and allow them talk freely a case study design was adopted with semi-structured interviews. Also staff opinions are heard to ascertain the effectiveness of the intermediate care service for the patients whom they have assessed. It was not known before what holistic effect intermediate care has on the patient or any unintended consequences, for example, if the patient is lonelier being treated at home rather than hospital.

From the literature review in chapter four it was found that no case studies matched the methodology of this study, therefore this research is innovative and will add to the body of knowledge that exists on intermediate care. With specific reference to intermediate care the literature review revealed certain issues that are necessary to explore in this research. Chapter three presented the theoretical underpinning to this research. This research is patient-centred and the reason they are receiving care at home or hospital is because they have suffered an injury which affects their ability to look after themselves needing assistance with daily activities. Therefore, in order to capture the patient experiences of care received, data must be analysed in a holistic way encompassing all patient effects such as the physical, psychological, social and

environmental issues. These factors that make up the holistic analysis approach were derived from the bio-psycho-social model (Engel, 1977) and the Comfort theory (Kolcaba, 2010). Therefore, the chosen methodology of case studies will answer the proposed research questions and utilise these four main headings in the data analysis.

Burns and Grove (2009) explain that qualitative research is a systematic, subjective approach used to describe life experiences and give them significance. Also, that within a holistic framework it allows the exploration of the depth, richness and complexity inherent in phenomenon (Burns and grove, 2009). The phenomenon explored in this study is that of a new health care change and the life experiences within the new and traditional routes of care. The complexity of care experienced will be unpicked using the method of applying themes to transcripts gained from participant interviews. The subjectiveness of the experience gives the patient as service user an opportunity to give feedback about their care experience and with more than one participant comparisons can be made to determine similar experiences.

5.2 Case Study Methodology

According to Taylor (2013) the case study approach allows for exploration of complexity from multiple data sources, is situated in the real life setting, is suited to nursing research where phenomena are complex and based in realities and is contextual with thick description enabling others to make judgements about the relevance of findings to their own situation. The exploratory multiple case study design used in this research allows for a holistic form of inquiry suitable for the sample population. Gangeness and Yurkovich (2006) argue that case study design fits well into the meta-paradigm of nursing consisting of person, environment, health and nursing. Therefore, again it is seen the components of this methodological approach matches the conceptual design and theoretical underpinning of this nursing research study. This research is qualitative inquiry about the lived experience of patients through a health care pathway, examining holistic effects of health care delivery in two different settings or environments.

Yin (1994) defines the case study research method as an empirical inquiry that investigates a contemporary phenomenon within its real-life context. Yin (1994) presented applications for use of the case study approach which are to explain complex causal links in real life interventions, to describe the real-life context in which the intervention has occurred, to describe the intervention itself and to explore those situations in which the intervention being evaluated has no clear set of outcomes. Therefore, this study utilises the case study method to describe the real-life context in which the intervention occurred, describes the intervention itself and explores situations where the intervention being evaluating has no clear set of outcomes. This achieves obtaining data from the lived experiences of participants on two different care pathways in order to analyse and construct the answers to the research questions.

Crowe et al. (2011) supports this by stating the case study approach can be used to describe in detail a patient's episode of care, explore professionals' attitudes and experiences of a new policy, service development or more generally to explore contemporary phenomenon in its real life context. Therefore, these definitions justify the use of the case study approach in this study, where both patients' and staff members' experiences will reveal how a service change resulting from policy change has impacted care delivery systems. It will reveal the real life context of care at hospital or home and the impact of the new service of intermediate care.

Stake (1995) further defines case studies into intrinsic, instrumental or collective. Intrinsic concerns a single case or unique case to explain a phenomenon, where instrumental is broader where the case study is not an end in itself but seeks to understand some other or broader phenomenon (Stake, 1995). The collective case study involves studying multiple cases to gain a broader understanding of the particular issue (Stake, 1995). Crowe et al. (2011) give examples of collective case studies such as workforce reconfiguration, the implementation of electronic health records in hospital and students' ways of learning about patient safety considerations. By enlisted multiple cases allows for similarities and differences to be drawn between cases (Baxter and Jack, 2008) and this it can be argued gives more reliable results rather than using just one case to explain a phenomenon.

Crowe et al. (2011) believe the steps involved in the case study method are to define the case, select the case, collect and analyse data, interpret data and report the findings. In contrast, Yin (2003) believes there are three steps to case study design of defining the case, selecting the case study design and using theory in design work. Yin (2003) goes on to say there are a variety of sources of case study data such as interviews, documents and direct observation where it is important to triangulate data from multiple sources to show a robust process has taken place. He also advocates using a case study protocol, exploring rival explanations, presenting the evidence with clarity before undertaking data analysis and generalising from the results (Yin, 2003). It must also be decided on whether the case study is explanatory to explain presumed causal links in real life interventions, exploratory to explore situations in which the intervention being evaluated has no clear single outcome or descriptive to describe the phenomenon in its real life context (Yin, 2003).

It is important to understand what Yin (2003) meant by using theory in case study design and having a case study protocol. He advises that a case study should start with some theoretical propositions to make it easier to implement which are not akin to grand theory, but simply a set of relationships such as a hypothesis or story about how and why acts, events and thoughts occur (Yin, 2003). The advantages of this can be interpreted as it narrows the focus, saves time and helps the case study contribute to the particular field of knowledge being studied. Baxter and Jack (2008) support this saying the researcher should have propositions at the start to limit the scope of the study and increase feasibility of completing it.

Yin (2003) says that a case study protocol is optional, but it is helpful to have a set of questions for the researcher while collecting data like a 'mental framework' to maintain the line of inquiry. He also advises maintaining a sceptical approach and to seek out any rival explanations, like a detective investigating a crime, where there may be alternative explanations as to why the crime occurred. This can be interpreted as the ability of the researcher to remain sceptical and not just reject alternative explanations that do not match with the original line of inquiry, but to investigate them which will increase the reliability and transparency of the study.

Tellis (1997) comments that data analysis utilised in the case study approach is one of the least developed aspects of its methodology, where the researcher relies on literature and experiences to present evidence in various interpretations. Yin (1994) advocates using a general analytic approach such as pattern matching, explanation-building and time-series analysis. Pattern matching involves comparing empirically based patterns with predicted ones, explanation-building where explanations are sought, compared and revised and time-series analysis to analyse events and relationships over a time period (Yin, 1994). Tellis (1997) believes Yin's data analysis approach relies on the theoretical propositions made for the study to focus interpretations of data on what research objective is. However, Yin also mentions the option of having a case description as a framework of the general characteristics and relations of the phenomenon in question.

Tellis (1997) pointed out that a weakness of the case study approach is its generalisability in its wider application to real life. Yin (1994) refuted this by comparing the method to a statistical approach where no theory may have underpinned statistical findings. Stake (1995) also defended the case study approach by describing it as naturalistic generalisation where a broad section of readers may have similar experiences and learn more about the phenomenon of interest. The next section will apply what has been learnt about case study methodology to this thesis.

5.3 The Use of Case Study Approach in This Thesis

It is necessary to utilise what has been learnt about case study design to construct a methodological framework for this study. Firstly, it is needed to define the case, select the case study design and data source. Two groups of patients are needed who attended the A & E department but took opposing paths of care in hospital or at home with the Early Response Service. In order to compare care at home with hospital care it would be unwise to choose two extreme cases. For example, a patient who attended A & E because they twisted their ankle is quite different from a patient who attended A & E following a road traffic collision with multiple fractures. Therefore there is a need to try and match like for like (same/similar injuries)

between the two groups which will illicit the subtle differences as to why one patient can go home and one cannot.

It is prudent to gain the views of the staff members who assessed these patients in an effort to triangulate data from multiple sources. This serves the purpose of a failsafe if the patient was unconscious or in too much pain or disorientated at the start of their journey, then the staff member can clarify the reasons why the admission or discharge was necessary. Also it helps represent the NHS as an organisation in comparing intermediate and secondary care from a professional's point of view. This helps give another slant on the real life context in which an intervention has occurred where there is no clear set of outcomes apart from regaining health status.

Baxter and Jack (2008) explain there are different types of case studies which explore single cases or multiple cases and each can have embedded units within them. The difference between a single case study with embedded units and a multiple case study concerns the context. A single case study with embedded units allows the researcher to understand one extreme case and multiple case studies allows for examining several cases to understand the similarities or differences between the cases (Baxter and Jack, 2008).

In this study although individual cases are explored, the context is two comparable settings, which then yield results, not only from the individual but also across the two groups of patients and staff members. Therefore, this is a multiple case study design and the unit of measurement is the patient or staff member representing a case. The case boundaries for the patient are the fact that they have attended A & E with an injury, the inclusion criteria for the study such as adults with mental capacity aged 18 years to 99 years and the application of the limitation of being able to find two cases who took opposing paths of care but had the same/similar injury. The data source are the semi-structured interviews with the participants. This achieves selecting cases who will describe the real life context in which an intervention has taken place as recommended by Yin (1994).

This case study design is exploratory in nature and aims to explore the phenomenon of intermediate care at home as opposed to hospital care. The design of a multiple case study is similar to that of Stake's (1995) collective case study design where there is exploration of differences within and between cases. Crowe et al. (2011) explain replication logic of case studies where one typical case can represent a theory or several cases test the theory if it can be replicated. Yin (2009) advises two or three cases for straight forward theory or five or more for more subtle theory.

Therefore, it is decided in this research to have a sample population of ten patients consisting of five patients who remained in hospital as inpatients and five who went home with the support of the Early Response Service. More than one case will help maintain balance if an extreme opinion or experience is revealed it can be put in the context of the cases. More than ten patient participant accounts would be too much to analyse within the remit of this thesis and would risk losing focus. This decision impacts the total number of staff cases as an opinion is needed on each of the ten patients, so ten staff who assessed the ten patients will be included, giving a total of 20 cases to analyse. The use of replication logic is not directly used to see if one theory in one case is replicated in another, rather an exploratory approach and explanation building is used by way of analysing individual cases and comparing them.

Yin (2003) advises having theoretical propositions at the outset to the case study like a blueprint to help narrow focus. Chapters two and three presented the conceptual and theoretical underpinnings to this research of holistic wellness and comfort encompassing the four themes of physical, psychological, social and environmental. Propositions have already been made regarding intermediate care being able to provide a successful care alternative at home.

Baxter and Jack (2008) state propositions help the researcher place limitations on the scope of the study. It can be seen that this study is exploring care pathways in two different settings and it has explained in chapter one the organisational change as to why a new service has come into being. However, it would have been too wide a scope to explore organisational decision-making and policy changes as well.

Instead this study has retained the narrow focus of remaining patient-centred and examining their experiences of care journeys.

By interviewing both sets of patients it will become apparent which path was most empowering towards independence and the difference in recovery experiences. If the Early Response Service emerges as a positive experience as compared to hospital there may be areas of improvement identified in the interviews that the service could act on. If the hospital stay emerges as a positive experience there may be areas for improvement like quicker access to therapists in secondary care. The answers to such questions can only be discovered by a case study method examining the real life experiences of participants.

This study discovers the patients' experiences of the new and traditional routes of care and shows the advantages and disadvantages of each. It reveals the partnership working between health and social services which is advocated in 'The NHS Plan' (DH, 2000c). It informs on how a chosen community service is delivering the new health agenda and most importantly how the patients feel and perceive their journeys through community based care and hospital based care within the NHS system. Therefore, its findings are crucial as feedback on how successful these health plans have been for this locality. It will also reveal professionals opinions about the criteria to ensure the Early Response Service is fully utilised and give a better understanding on what patients are suitable for the service.

From these experiences of care, aspects will be explicated and examined to make sense of the context of the phenomenon of intermediate care. The case study data analysis technique will be exploratory and explanation-building helping to draw comparisons between groups and arrive at analytic generalisations about the two care pathways. The reader is aware of the theoretical propositions for this study from the first three chapters where it is proposed that intermediate care can provide successful alternative care at home measured from a holistic viewpoint of patient experiences encompassing physical, psychological, social and environmental factors. In addition the case study protocol as described by Yin (2003) is the research questions set out in chapter one. The investigator has started with

questions that warrant answering on a new health service at home emerging and it is these research questions which will act as a 'mental framework' in analysing the data.

The investigator must keep an open mind and remain sceptical as advised by Yin (2003) as rival explanations may occur. From the literature review two additional themes emerged that were not expected at the start of this study: age discrimination and loneliness. These were seen as particularly challenging issues for the older patient. These themes can be seen as possible rival explanations or unintended consequences of a care delivery episode. This heightens the investigator's awareness of not having a too narrow proposition of what the data may reveal and to look for other explanations also.

The data analysis method used in this study incorporates Yin's (1994) general analytic approach such as explanation-building. The objective is to ascertain how organisational change has affected the real life experiences of people going through two different care journeys. Explanations are needed on how the injury affected them regarding their functional capacity which determined how much help they needed and ultimately which setting their care could take place. These explanations and by comparing cases help answer the research questions and determine the success of care at home or hospital.

Crowe et al. (2011) and Yin (1994) advise allowing the theoretical framework to inform the data analysis method because it helps integrate different sources of data and examine emerging themes. In application to this study it is known the four categories of physical, psychological, social and environmental are components of holism or wellness (chapter three) which comprise the paradigm. These themes were derived from the bio-psycho-social model (Engel, 1977) and Comfort theory (Kolcaba, 2010). In addition there are the additional themes of age discrimination and loneliness discovered in the literature review. Therefore it will be these four category headings which will be used to search for themes in the data whilst allowing any evidence on the two additional themes to emerge.

Crowe et al. (2011) explain two approaches to data analysis; the first is of a framework of data analysis of familiarisation, identifying thematic framework, indexing, charting, mapping and interpretation. The second is a coding frame where data is organised and coded to allow the key issues to emerge and to be easily retrieved at a later date. The coding method can then be applied to the whole data set (Crowe et al. 2011). The repeated reviewing and sorting of detail-rich data are integral to the process of analysis in the case study approach (Crowe et al. 2011). Yin (1994) also described pattern matching, explanation-building and time-series analysis.

In this study with the six subject headings collected to analyse the data, it was decided to incorporate a general analytic approach with explanation-building, but to acknowledge that patterns may emerge from the data; not a predicted pattern, but rather in the form of commonalities between cases. These commonalities would allow statistics to be formed for the results such as six patients felt lonely out of the sample group. Tellis (1997) believes explanation-building is a form of pattern-matching as the analysis is carried out by building an explanation of the case.

This study will not specifically address time-series analysis, but is examining care journeys over a period of time so it will be pertinent to extract any data regarding recovery rates or length of stay. The coding method (Crowe et al. 2011) will be utilised to search for the six headings in the data in the form of transcripts. For example, if a patient refers to not being able to go out and socialise due to their injury, then this statement would be coded under the social heading. Once all data is coded from the 20 cases then similarities and differences can be searched for between each case to aide explanation-building.

Baxter and Jack (2008) explain that it is not the case study's design intent to be able to generalise to larger populations, but rather to generalise to other situations. Yin (2003) supports this saying analytic generalisations depend on the study's theoretical framework to establish logic in other situations where similar concepts, theories or sequences may be relevant. Therefore, this study will be useful to other

intermediate care teams to inform them about its results in this context, but may not be applicable to wider populations in the NHS delivery system as a whole.

This research will add to the body of knowledge on intermediate care and its findings can be compared to other intermediate care studies. However, Linertova et al. (2011) warned that due to differing times of follow-up of other studies gaining comparable data in a systematic review is troublesome. Thus, this research method is unique in its application to qualitative data and will not be exactly comparable to other studies. However, its findings will be reliable from the patients and staff perspectives on care pathways and it will achieve answering the research questions on intermediate care. Burns and Grove (2009) state that even though qualitative research is unique it is possible to find commonalities amongst studies.

One such commonality could be the case study approach. Holloway and Wheeler (2010) explain that experiences of people and phenomena are essentially context bound and cannot be separated from time, place, values and consciousness of the human being. Therefore, participants may have preconceived ideas about the NHS and will be interpreting their care pathway experience individually about what it means for them in their time, place, setting and mind. This means that it is important to enlist more than one participant in this case study method so that similarities and differences can be drawn between accounts, but to also recognise the individual lived experience. This will be done by presenting qualitative extracts of data in this thesis. This enables the reader to put each theme meaning derived from data into the context of experience for that person.

5.4 Data Collection and Analysis Procedures

The composition of the cases, data collection and analysis procedures have been briefly described above. The following section will provide more detail of the research processes in this study.

5.4.1 Data Collection

A qualitative case study approach of interviewing both sets of patients has taken place to gather rich data on patient journeys. Interviews with participants has

facilitated the application of case study approach as described by Yin (1994) to describe the real life context in which the intervention occurred, to describe the intervention itself and explore the outcomes of the intervention. The intervention in this study is the care received at home or hospital. Tellis (1997) comments that interviews are one of the most important sources of case study information and interviews can be open-ended, focused or structured.

It appears to examine experiences of those patients who did not meet the home care criteria but suffered similar injuries, has not been suggested before. This patient group who remained in hospital reveal their opinions if they wanted to go home or stay in hospital and if they had a choice in that decision. By the same token, the home patients express their opinions as to whether they should have stayed in hospital.

The data collection plan was to enlist participants from the A & E department in the research locality. The A & E manager, staff and research and development department were informed of the study and were co-operative in facilitating visits to the department. The research interviews were planned to take place over a six month period. There occurred slight time delays in finding two similar patients who took opposing paths for example, six fractures, two collapses and two medical reasons for admission.

The study acknowledges that each individual is unique in their response to injury and is guided by the type of patient the Early Response Service treats. The majority of patients whom the Early Response Service treats are orthopaedic patients who have suffered falls (with or without fractures), and a minority of medical or surgical patients. Therefore, the emphasis will be on finding two cases with the same/similar injury that went opposing paths of hospital or home and examining the reasons for this. In addition to capture their experiences of the care received.

It is anticipated that this will provide enlightenment as to the type and nature of the patient who is suitable for home care and those who are not, as well as what their care journey involves. The objective for the ten cases studies then was to pair

participants from each group with the same/similar injury. At the start of data collection a table was drawn with two columns so when one patient was found with a particular injury the investigator knew they had to find another patient with the same/similar injury but who was on the alternative pathway. When the ten cases were found this 'matching table' would be complete and represent the chosen cases' injury type.

The pairing of participants helps aid data analysis to find out what is important in care delivery and the similarities and differences between two people with the same injury but in different settings. This process was largely determined by identifying one participant in the hospital or at home group and waiting and searching for a similar patient to be admitted in the opposite group. For example, if a patient with a fractured clavicle was admitted and kept in hospital, then the researcher would liaise with the district nurse at the A & E department when the same injury appeared on the admission list and the patient was being discharged. That patient was then approached to see if they would like to participate in the research study. This resulted in a pair with the same/similar injury but who took opposing care pathways.

For this matched pair it was important to gain their views on the same issues. For example, if help in assisting with meal preparation is important to the patient at home, does the patient on a ward feel disempowered that their meal is delivered direct to them without an attempt to prepare it themselves with minimal assistance? If this is the case it could have a knock-on effect on how dependent they feel on care givers and impede a speedier recovery. Psychologically, dependency on others can impact on their feelings of self-worth (Lancer, 2012). In this example it would be prudent to discover if the patient has been assessed by an occupational therapist on the ward and what activities were they restricted to practising before returning home.

Obviously, when the plan for a discharge from hospital is imminent, it is the multi-disciplinary team's responsibility to ensure the person has optimised their self-care ability before leaving. Does this take a longer time in hospital as opposed in the community or is it dependent on the patient's level of functioning? The different factors that hasten or impede independence were important to discover for service

resource allocation. Some older people may become disorientated or confused whilst in hospital (Brawley, 2007). Alternatively they may be too fearful to return home without support. Therefore, the interview topics in the data collection method must relate to the analysis of data utilising the six chosen themes of physical, psychological, social, environmental, age discrimination and loneliness. However, individual characteristics of a case such as coping ability, family support and severity of injury/illness must be taken into account.

It was neither ethical nor professional for the investigator to be wandering around a busy A & E department approaching patients at random. Therefore, in order to access potential participants the district nurse who worked at the A & E department and was an ERS (Early Response Service) referrer helped recruit potential participants. This took the form of her checking admission lists so the investigator would not be exposed to patient demographic details before they gave their consent to an interview. She helped narrow down the search for participants this way and would approach potential participants asking if they would be willing to talk to the investigator about the research.

If patients who were approached agreed to participate, an information sheet was given to them (Appendix 6). It was at this stage that the investigator explained their address and telephone number was needed in order to arrange an interview up to six weeks later by which time they would have experienced their care pathway which was the focus of the study. They were also asked to consent to the staff member who carried out their assessment to be interviewed about their care journey.

Patients were assured that their care would not be affected in any way by their decision as to whether to participate or not, or whether they consented to the staff member being interviewed. If they did not consent to the staff member being interviewed then it would not take place but the patient's interview would still go ahead to gather their rich care experiences. It was necessary to obtain consent in writing regarding the above and to gain a further final consent on the day of the interview in case any participant had changed their mind or had forgotten the study details. Therefore, in respect of the patients having suffered an injury/illness as to

why they were in A & E, it was deemed more ethically sound if the staff interviews took place after the patient interviews so they are in an optimum state of physical and mental health when making decisions. Thus, they will have all the study information when first approached, but upon a second approach to interview them they will be free to change their mind until the point when they give final written consent and the interview begins. It was also explained that beyond this point if they wish to pull out that interview data already collected will be used anonymously.

Staff participants were also free to consent to being interviewed. At the time of identifying the patient participants the staff member who assessed them was approached and given an information sheet (Appendix 5). It was explained to them they would only be interviewed if the patient consented and their interview would take place after the patient's.

The initial idea was to interview only ERS referrers. However, this would be unethical to interview the first professional who assessed them before the patient could consent to them being interviewed and the patient had not had time to experience their care pathway. For a member of staff at A & E to try and remember a patient approximately six weeks after their initial assessment may again pose problems. The researcher overcame these problems by interviewing the nurse who cared for the patient on the hospital ward for a period of time so could comment on the initial assessments as to why they were admitted to the ward as well as the subsequent care received. For the home patients it was the ERS member of staff who received the initial information on the patient from A & E, performed the initial assessment and became their nurse case manager to co-ordinate their subsequent care in the community.

The objective of interviewing staff members was to capture a professional's opinion on each case. The researcher felt that without this information important data would be lost or not explored. Walsh (2001) and Yin (2003) advises triangulation or covering all bases, where multiple methods of data collection are used to counter weaknesses of the study like a narrow angled view point. Different methods of data gathering are not used such as documents or direct observations in this study;

however multiple sources of data are gained from the three types of cases. These three types of cases are the home patient, the hospital patient and the staff members who assessed them acting as units of measurements.

The staff members' professional views can help put each individual case in the context of the care pathway they are experiencing and enlighten our understanding of why particular patients are better suited to care at home as opposed hospital. It is quite possible that a patient may be unconscious, distressed or delirious upon admission to A & E and not remember the start of their care journey or why particular decisions were made and why they were in that particular setting. Therefore, the staff member's views who assessed the patient acts as a failsafe to fill in any gaps and gives a service or organisational perspective to care delivered. The ten staff who assessed each patient case with particular reference to their care setting were interviewed. However, in order for the staff member to be interviewed about the patient's care experience the patient needed to give consent and in all 10 cases patients gave their consent.

Staff participants who were interviewed were assured of anonymity. There was no reproach on the assessment outcome or decision-making process, rather an understanding was needed of what nature of patients met the Early Response Service criteria and if there was a need to adapt the criteria. They made crucial comments on resources needed to facilitate discharges and gave fresh perspectives as to the reasons why some patients have to stay in hospital. It is not about their professional competence and their professional judgement was not under scrutiny: rather it was about ascertaining their assessment decisions against set criteria, for example, what Early Response Service resources would have enabled a discharge in this case? This information would help inform practice in that the Early Response Service will know where to target their finite resources.

It was anticipated that improvements may be suggested and this will give an insight on how effective this new service is working in light of national plans to expand intermediate care (WAG, 2005). This information can only be gained from the professionals who are using the service on a daily basis. Therefore, this research

was undertaken by way of interviews with each individual patient and their assessing staff member totalling 20 cases.

A structured interview was avoided to enable the patient to talk freely about their experiences and questions were used as prompts. Five patients who went from A & E to hospital wards and five patients with the same/similar injuries who went home with the Early Response Service were interviewed. The patients were asked about the start of their journey when the injury occurred to the end when recovery was achieved. The staff members who were involved in assessing the patients' conditions were interviewed using the semi-structured interview approach after the patient consented to this. Bryman (2008) explains that the semi-structured interview involves the researcher having a list of questions or specific topics to be covered as a guide, but the interviewee has a lot of leeway in how to reply. Questions may be asked that are not on the guide led by the participant's answer but all interviewees will be asked questions with similar wording (Bryman, 2008). 20 transcripts were collected to analyse. Please see Appendix 3 and 4 for interview questions.

The study's inclusion criteria involved adults over the age of 18 years and up to 99 years old which resulted in a mean patient age of 80.5 years. It was anticipated the study would capture more older people than young, because they are the most frequent ones to need help after suffering an injury/ illness (DH, 2001). Both males and females were included to give a fair representation of gender. The participants were approached on an injury basis irrespective of their personal demographics.

The interview did not take place at the initial introduction stage because factors such as pain and convenience had to be taken into account, also patients would not have had time to experience their care pathway. Participants were offered a summary of study findings if they wish to know the outcome of the research. The investigator carried health board identification at all times to reassure participants that when the subsequent interview took place at their home that they are a genuine researcher and member of NHS staff.

A consent form was signed by the patient taking part (Appendix 8) and by the staff members who were interviewed (Appendix 7). They were reassured that their names will be not be used, but would be referred to as case study A, B, and so on. A dictaphone was the method used for interviews and obviously a quiet room sought where privacy could be assured.

To summarise the data collection method in time order: potential participants were approached at A & E, an information sheet given and consent gained to know their contact details if they wish to participate, consent was gained to interview the staff member who assessed them and it was explained that the staff interview will take place after their interview just in case they change their mind. It was explained they are being interviewed several weeks later to give them the opportunity to experience the care pathway.

All patient interviews took place in their homes. This was because they all requested it to be so as they felt they could have time to fully experience their care pathway and would be recovered enough to be interviewed. Only one ward patient wanted time to think about his participation and he was interviewed at home a couple of weeks later. On some days interviews were able to be booked in the morning and afternoon which reduced the travelling time back and forth the chosen research area which was a 100 mile return journey.

All staff interviews took place after their matched patient interviews and all ten patients consented for their assessor to be interviewed. Staff members were interviewed at their place of work by prior arrangement in a quiet room. All interviews were recorded and were shorter in length than the patients, lasting between 15-25 minutes whereas the patient interviews lasted between 30-60 minutes. No time limit was imposed on interviews.

Bryman (2008) says the interviewer must expect the unexpected like disruptions or environmental noise which may be out of their control, but one must try to limit its impact on the interview. One patient participant stopped the interview as they wanted to put sausages into the oven. Another participant's relative interrupted the interview

to list the chores they had done for them that morning. Two participants were distracted by stroking their animals and talking about their companionship with them. Two participant interviews were interrupted because the doorbell went. At two participant homes ERS carers turned up whilst the investigator was there. One carer visited to drop off a pressure relieving cushion for a patient and the other carer to make the bed and empty the commode. The investigator redirected the participants to continue with the interview after these disruptions.

Field notes made at the time of interviews provide insight into the data collection process which helps the reader understand the real life context of conducting research. They can act as a form of data source to be included in studies, especially with regard ethnography or direct observation qualitative research (Yin, 2003). However, they are included in this chapter not as a source of data, but as a reflective insight to give the reader an understanding of being a novice researcher. The following notes are extracts from the investigator's notes to give a brief insight into the data collection process undertaken.

Walking through a busy A and E department made me feel very conscious of patient confidentiality. I walked passed injured patients and staff using computers, so found myself looking down or turning away so I would not be exposed to any information whether it was verbal or written which was not relevant to my own research. In the sanctity of the office we began trying to identify participants on the computer system based on the type of injury search. I was unable to look at the computer screen in case demographic details appeared so was reliant on the district nurse's analytical skills. I feel I did my best to uphold patient confidentiality within a busy department.

During one interview the voice recorder did not work. I changed the batteries and it still did not work. I used my spare dictaphone and that didn't work either! I tried changing the batteries again and the tape but still nothing worked, so I hand wrote the whole interview. The participant did not mind that I was writing and occasionally I would look up and nod to acknowledge that I was listening, but it was obviously tedious work compared to recording an interview. Afterward I examined each voice recorder and found that an unlabelled button had moved slightly which must have happened in my bag as I was carrying the machines into the house. I moved it back and discovered it was the pause button, that is why it would not play or record.

It is a lesson learned that I thought I knew my equipment and carried a spare as good preparation, but they were both made by the same manufacturer and this pause button was not labelled. I tried to turn this into a positive experience that at least I had a script already transcribed from the interview. I do not feel it affected the study's credibility with the interviewee as they could see I had brought a spare

machine and batteries so was well prepared and they enjoyed recounting their experiences.

At one interview I was invited to sit on an armchair which had a vibrating cushion on which activated when I sat down, so took me by surprise. At another interview the participant had spent time abroad and was insistent that I knew that they themselves did not beat slaves of a different ethnicity; that they were kind to them. I acknowledged the comment and reassured them that I believed the comment, before re-directing the discussion back to the interview questions.

5.4.2 Data Analysis

Crowe et al. (2011) and Yin (1994) advise allowing the theoretical framework to inform the data analysis method because it helps integrate different sources of data and examine emerging themes. In application to this study it is known the four categories of physical, psychological, social and environmental are components of holism, comfort and wellness (chapter three) which comprise the paradigm. These themes were derived from the bio-psycho-social model (Engel, 1977) and Comfort theory (Kolcaba, 2010). In addition there are the themes of age discrimination and loneliness discovered in the literature review. Therefore it will be these six headings which will be specifically searched for in the data whilst allowing any further themes to emerge.

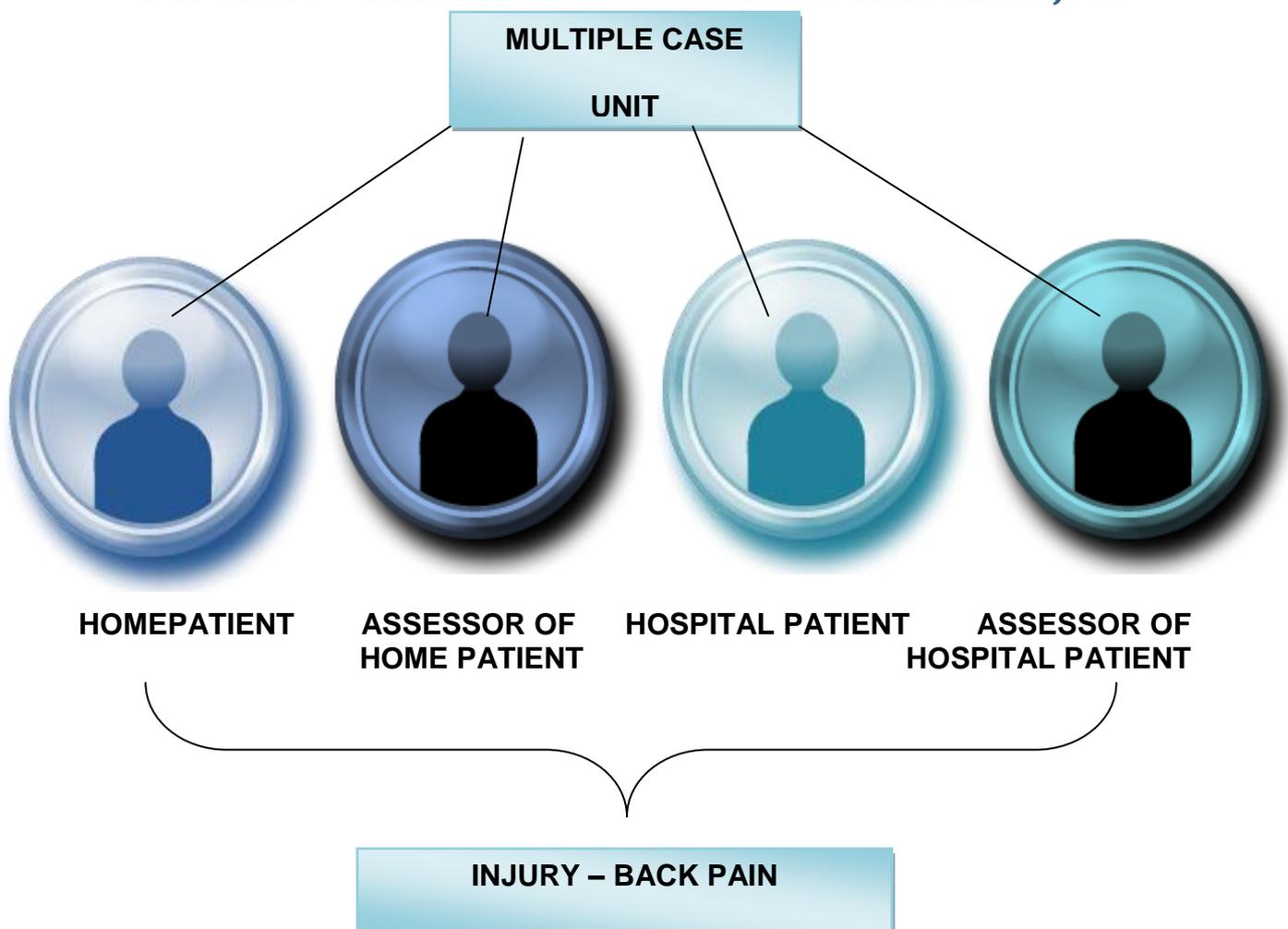
The data were also searched through for any information pertaining to answering the ten research questions which would inform the overarching research question of how successful intermediate care was at treating patients at home as opposed hospital. The research questions are akin to having a mental framework or protocol as described by Yin (2003). This helps narrow and retain focus when examining the data so that the research objectives can be met.

Bryman (2008) says that the process of transcribing in qualitative research has the advantage of keeping intact the interviewee's words, but the disadvantage of the amount of text to be analysed which can be time consuming. In total there were 20 transcripts to analyse. To protect anonymity each written transcript was given unique identifier codes. Also on each patient transcript was the reference number to what member of staff had assessed them. The patients and staff members are the units of measurement in this multiple case study. Therefore, even though there were paired

participants on their injury and having care at home or hospital, there was also the need to link the staff members' transcripts to the appropriate patients.

In other words each patient case had a staff member case who assessed them so with pairing them together it equalled a total measurement unit of four cases pertaining to that injury experience. This gives breadth to the analytic process as explained by Thorne (2000) from looking at individual experiences of the patients and cross referencing them, to also cross referencing the staffs' professional account in each case. This will give us more information on the factors involved in caring for people at home or hospital and their suitability for this type of care. To further explain how four individual case studies fit into a multiple unit, please see diagram below.

DIAGRAM 3 - EXAMPLE OF A UNIT OF FOUR CASES PER INJURY



Bryman (2008) points out the advantage of using software for data analysis like saving the manual labour of cutting, pasting and coding. However, it was decided not to use a computer software programme to analyse the data due time constraints and to avoid complexity of the analytical process. The traditional method of writing up each transcript and reading through to code with a highlighter pen was utilised in this study.

For each paragraph or few sentences spoken a key word was formulated from the topic of discussion and these were then grouped under the main theme headings for analysis and comparison between participants as well as between home and hospital patients. Through analysing all transcripts, comments emerged pertaining to each of six themes. Any comment found that directly related to answering the research questions was highlighted with a different colour pen. From a policy point of view it is important to know if this care at home service is working so questions such as whether the hospital admissions were necessary and the reasons for those admissions must be answered. Along with knowing general feedback of patient satisfaction and any positive and negative comments made.

A coding frame is where data is organised and coded to allow the key issues to emerge and to be easily retrieved at a later date. The coding method can then be applied to the whole data set (Crowe et al. 2011). The repeated reviewing and sorting of detail-rich data are integral to the process of analysis in the case study approach (Crowe et al. 2011). By utilising this coding method, when each individual case study is analysed and coded for the different themes, there is a need to group together statements from cases pertaining to a theme heading. In other words the unit of measurement is the single case but in order to discover similarities and differences between cases their comments on a particular topic such as social activities can be grouped together under the social theme. Therefore, multiple cases are converged about their opinions on a particular topic such as social activities.

This study will not specifically address time-series analysis, but is examining care journeys over a period of time so it will be pertinent to extract any data regarding recovery rates or length of stay. Once all data is coded from the 20 cases and the

similarities and differences found between each case then the explanation-building process can start. Yin (1994) describes this as building an explanation about a case, identifying causal links, a series of iterations such as theoretical interpretations or comparison of cases and to finally return to the propositions of the study.

Therefore the objectives for the data analysis are to collect data from each individual case, to compare the two patient cases with the same injury who went to different settings, to compare these with the related cases of staff member's accounts on these patients, which represent the unit of measurement of four multiple cases. Next to compare the two groups of hospital and home patients for any group similarities or differences and to examine the staff cases as a group for any commonalities in comments made. By achieving this objective the answers to the research questions can be found and the components that help or hinder the attainment of holism and comfort found.

5.5 Ethics

Ethical approval was sought from the Local NHS Research and Ethics Committee and the Research and Development Department at the site where the study took place (Appendix 2). An original idea of following the care pathway from point of referral to the Early Response Service was initially rejected by the Ethics Committee because it meant the staff members' interviews took place before the patients' interviews, so the patient had no opportunity to fully consent. Therefore, the proposal was amended and staff members were advised to look at their previous notes on patients if they wanted to refresh their memories about a particular case as their interviews were taking place after six weeks of meeting the patient.

Another minor concern mentioned by the committee was that the staff members may feel their decision-making and professional judgement was being brought into question. Therefore, the second version avoided specifically asking questions to staff about their decisions. Instead it was left to open-ended discussion on questions such as what they felt would have happened if the patient took the opposing path of care. The staff member was free to express what their concerns were and what they thought the reasons were as to why a patient took a particular path without specific

scrutiny on their own personal decision-making in each case. There were discussions with the University and Research and Development department in the chosen locality about the research proposal, but no other problems arose as they just wanted information about the study and its progress.

Participants were reassured that all the information collected during the study would be kept confidential on paper and electronically under the provisions of the Data Protection Act (1998). Any patient excerpts used was kept anonymously and referred to as case study A, B, and so on in time order fashion. Any staff excerpts used was kept anonymous and referred to as staff case 1, 2, etc. However once all matched five sets of four cases were analysed, for example 1 + 2 + A + B = a matched unit of four cases for a particular injury, it was decided to use pseudonyms to make the case study presentation of evidence more personal rather than a letter or number. Therefore, patient case study A became known as Mrs Atkins and staff case study 1 became known as Nurse Alexander and so on until each case study had a pseudonym.

No actual sound recordings of face to face interviews were used in any reports or publications rather they were used by the investigator to create transcripts and then destroyed. Participants were given an information sheet about the study and a consent form to sign to ensure they were giving their informed consent. Participants were free to withdraw from the research at any time but if it is post-interview it was explained that data may still be used unless they specifically asked it to be destroyed. They were also informed that there was no reimbursement or payment for being interviewed.

Participants who have prior experience of being cared for at home or hospital were able to draw more accurate conclusions of which care pathway suited their needs. However, it is not necessary to have prior experience as the investigator is looking for themes of what elements are important in recovery both at home and in hospital, and then will compare answers before drawing conclusions. Their perceptions of the opposing care pathway will be based on factors such as how they imagine they would have coped. It is the investigator's role to distinguish between real experience

and perception. Their condition and self-care ability has ultimately decided the care pathway they are on, but it is important to professionals and the criteria they work by to elicit the different elements that has resulted in them following a particular pathway.

The staff members were reassured that their decisions are not being questioned or the subject of the study, but their knowledge on which patients suit the criteria or how more patients can be helped to go home with more resources was needed. This will enable the Early Response Service to ascertain if they can meet these identified needs, where to target resources and to have a clearer idea on the type of patients it can help bring home. This study aims to be beneficial to staff in bringing forth possible resource issues encountered and listening to possible remedies. It can only serve to tighten criteria and help inform managerial decision-makers where resources are needed and how well this service is performing in saving hospital beds.

If a staff member or patient got upset during the interview it would have been stopped and a break taken. The participant would have been asked if they wish to continue or to leave the research project. They were informed that they could talk freely to friends or family about the research before the decision to take part is made. The investigator had no objection to a member of family being present as long as it is the participants' views that are heard. The participants were given up to a week to decide if they wished to participate or not.

The investigator does have a dual role of previously being both a nurse in intermediate care and the investigator. Asselin (2003) states insider research or researching your own work setting can bring the credibility of the health study into account. The nurse researcher will share an identity, language and common professional experiential base with nurses in the study. Therefore, central features are taken for granted and can become invisible (Delamont, 2002). Asselin (2003) lists disadvantages like bias-risk, culture assumptions, participant expectations, role confusion and lack of objectivity. Qualitative research methods such as interviewing

and the subsequent data collection and analysis are at risk of the familiarity problem affecting the results which will have implications for practice.

Walsh (2001) advises triangulation or covering all bases, where multiple methods of data collection are used to counter weaknesses of the study like a narrow angled view point. This study's method of collecting both staff and patient data will help balance any insider issues in that it takes a multi-view point. Working in a new field of employment helped make the previously familiar more strange. However, common language would be impossible to rule out completely, so a heightened awareness was needed in interviews if comments were made about the knowledge the investigator possessed on the service and to ask the participant to fully explain what they meant by that statement. In other words, not to take for granted that the investigator understood the meaning of the topic they were discussing.

The investigator endeavoured to remain completely impartial and did not let their prior experience of working in this area affect or influence any answers given. Training days provided by the Research & Development Department on good research conduct and skills were attended and expert advice from the academic supervisor regarding researcher conduct was given; to remain objective and impartial. The investigator was not a referrer to the Early Response Service so had not done exactly the same job as the majority of staff interviewed.

The research design and methodology has been constructed to protect participants' anonymity and vulnerability. The design of having an introductory stage and a later stage (up to six weeks) where the interview takes place is essentially not only a period where the care is experienced that they will be questioned about takes place, but gives the patient participant time to recover from their presenting injury/ illness. Therefore, they will have two opportunities at the beginning and towards the end of their recovery to deliberate their participation. Even though they were asked for their consent if the staff member can be interviewed at introductory stage, this again was asked on the day of their interview. Staff then had the option to participate in an interview or not and there was no reproach if they did not wish to do so.

5.6 Validity

Baxter and Jack (2008) state that in order to achieve validity or credibility in case study research the investigator has a responsibility to ensure the research question or propositions are presented and the case study design substantiated. Also that the sample population is appropriate, data are collected and managed systematically and the data are analysed correctly. This study has hopefully achieved this; although it has not triangulated data methods but rather triangulated data sources of three types of cases to help increase reliability of results. Baxter and Jack (2008) state a multiple perspective allows for comparison of data, idea convergence and confirmation of findings to increase the quality of the study.

Kohlbacher (2006) goes further to explain that case study validity involves addressing objectivity issues, construct validity, internal validity, reliability and generalisability. Objectivity issues or internal reliability was addressed in the ethics section regarding the insider perspective. It was explained the investigator no longer works in this field, has attended research workshops, sought advice from the academic supervisor and had a heightened awareness of probing any common language statements made in interviews. Therefore, effort was made to make the study as reliable as it possibly could be and the investigator's philosophical stance made transparent.

Construct validity is whether the evidence correctly corresponds to the theoretical propositions (Kohlbacher, 2006). Usually validity is used in quantitative research, but Sarantakos (1994) claims it can be used in qualitative research. In this study the qualitative data gained from the participants must be accurately interpreted by the investigator so that there is correct correlation between the data and the conclusions reached. This is helped by presenting qualitative extracts in the results and showing transparency in how particular concepts or conclusions have been reached from the data. Kohlbacher (2006) believes triangulating data sources helps and that qualitative data presents such rich detailed data which can support any conclusions reached. Yin (1994) talked of rival explanations and the investigator must be transparent about data which may emerge which is in contrast to propositions held.

Kohlbacher (2006) explains that internal validity concerns the postulated relationships between concepts as researchers could potentially with careful editing make data fit their proposition. The internal validity of this study is helped by presenting qualitative extracts in the next chapter and demonstrating how a particular statement matches one of the six themes. Kohlbacher (2006) advises continual cross-checking of data for accuracy and to rule out ambiguity. Therefore, statements will only be utilised that provide a direct link to the theme or proposition, for example, a patient talking about how her body felt exhausted would link to the physical theme and the experience of loneliness could relate to both the social and psychological themes.

Bryman (2008) also defines internal validity as achieving a good match between the researcher's observations and the theoretical ideas they develop. This study presents qualitative excerpts and themed analysis from which conclusions were reached to answer the research questions. Therefore the internal validity is quite strong in ensuring the participants opinions are heard and understood. It is the participants' data that will answer the research questions and confirm or refute the theoretical propositions.

Bryman (2008) explains that in qualitative research external reliability of study replication is a difficult criterion to meet. Kohlbacher (2006) agrees and says that there is a problem in trying to replicate studies as the researchers will be different and may generate different findings. Kohlbacher (2006) believes that reliability should be addressed by presenting with transparency the investigator's propositions, methods, data generation and its interpretation, so that the public can have faith its findings.

Linertova et al. (2011) found case studies on intermediate care were difficult to compare in a systematic review. Therefore, grouping this study with others may be problematic due to the different research designs and methodology. However, there is potential for generalisability between studies if common findings are presented and this difficulty acknowledged. Along with looking for common approaches such as the case study design to make comparisons between studies.

The obvious limitation to this study is the small sample size with ten patients and ten staff participating. However, with the wealth of information that has come from the case studies the results can be generalisable to a wider population in another locality who are experiencing intermediate care initiatives. This study presents rich qualitative data from the patient and staff experiences of different care pathways. Other localities will hopefully find this data extremely useful in designing or evaluating their services as it has been the service user that has provided feedback. However, the external validity of trying to generalise or externally validate the findings across other care settings like nursing homes or day hospitals may be problematic.

Kohlbacher (2006) defines generalisability of a case study where the inferring process links to the theoretical reasoning which can be useful to understand the situation, intervention or phenomenon. Therefore, conclusions reached by extrapolating from data provide a greater understanding of the context, situation or the organisation. Given that this study is examining real life experiences in the two different care settings of secondary and intermediate care, which are parts of the same complex organisation, the NHS, the results give insights into how some of the system parts are functioning. A whole system is affected by a change in one part where it has a 'knock on' effect on the other parts in the system (Senge, 2006). Therefore, being able to provide care in the community saves on hospital bed days and it is in this sense that the results of this study may be of interest to the NHS as a system.

A potential risk to this study was the lack of being able to identify suitable participants as quickly as hoped due to extenuating factors. These factors included the norovirus meaning wards were shut and there were fewer orthopaedic admissions to A & E to choose from. This barrier was overcome with the help of A & E staff and ERS staff who were able to assist with searching and introducing the research to potential participants whilst maintaining patient confidentiality and privacy.

5.7 Conclusion

This methodology chapter has sought to present how the case study method came to be chosen and utilised. The processes of data collection and data analysis techniques have also been presented. By providing depth and detail to the methodology of this study increases its reliability and validity of its results.

It has been learnt that the research takes the form of qualitative inquiry of multiple case studies by way of semi-structured interviews. The conceptual design, theoretical propositions, protocol and mental framework as described by Yin (1994) were derived from what was discovered in chapters one to four and the author's stance of this remaining a patient focused study in the realms of nursing practice which examined the holistic path to independence, wellness or comfort in different care settings. The six chosen headings and the aim of answering the research questions helped inform the method of data analysis.

The research design of case study approach has benefitted professional practice through the new understanding gained regarding the phenomenon of intermediate care. The results of this study enable feedback to be given to the Early Response Manager and A & E staff to recommend areas for possible improvement in practice and service development. It is beneficial for secondary care staff to have an awareness of patient journeys through the care system in comparison to the community. Also, the data analysis enlightens Early Response staff regarding what happened to patients who did not receive their service and had to stay in hospital. Utilising the case study method the phenomena of intermediate care delivering successful alternative care has been explored.

This study discovered the care experienced by patients in hospital compared to at home, and how their recovery was affected by whether they received acute secondary care services as opposed intermediate care services. With more acute care moving to the community setting (WAG, 2005) this research has demonstrated how the community is coping and any future plans will need to acknowledge its strengths and limitations. The research has had the potential to be an empowering

experience for patients as their voices have been heard. It also gives professionals an insight into how the patients receiving their service actually perceive it.

Locally, the research gives another source of rich data of how successful the Early Response team is working with A & E to prevent inappropriate admissions to hospital. A case study analysis like this of how a locality is performing in delivering health plans in preventing inappropriate admissions has never taken place in this locality before. Most importantly it discovered patients' experiences through the systems that have been set up recently in response to national targets.

It was hoped that all patients have positive journeys through care systems. Any negative feedback which has occurred from patients in hospital or at home in this study can be seen as areas for improvement for the future of the service. Audits can prove the service is successful, but the pairing of participants' journeys has produced insightful rich data from their point of view of receiving care at home or in hospital. Interviewing the professionals who assessed the patient has helped give clarity to the pathway the patient took in view of the Early Response Service criteria and capabilities of caring for people at home.

Nationally, the locality will be able to benchmark their service against other regions who are delivering on the same health agenda but in different ways. Every region across England and Wales has an intermediate care service, but not all have an Early Response Service. For example, one Welsh locality has Long Term Conditions Nurses, a Reablement team of therapists and Rapid Response Nurses who give intravenous drug therapy in the community to try and prevent admissions. The nurses did not at the time of this research directly link into A & E for patients who have suffered fractures who may be looked after at home with health care support workers in an immediate response fashion. Only the charity Age Concern offered help upon discharge for tasks such as shopping. Therefore, as well as learning from the research findings about their service delivery there is the possibility to create a 'gold standard' service from which other areas can look to this locality to benchmark.

The real life context of this research achieved through the case study method as advocated by Yin (1994) has produced insight on what patients are experiencing as a whole after suffering an injury and attending A & E in the current NHS system of care delivery. The full extent of generalisability to a larger population is cautiously anticipated as patients are unique individuals. Their age, health and whether the patient lives alone are factors which are needed to be taken into account and are stated in the research. This justifies a case study approach by semi-structured interviews as the patient will be talking of their own personal experiences. Success is measured by way of a positive experience of the care received and comfort gained in the four theme categories. If cases confirm the success of the Early Response Service it helps validate that it is an alternative type of care that works. Below is a copy of the time table for the planned research over the first year.

TIMETABLE FOR 1ST YEAR 2010-2011

TASK	Dec-Mar	Mar-Oct	Oct	Nov	Dec	Jan	Feb	Mar	April
1.Submit Proposal & gain Ethical Approval	6								
2. Preparation work	1								
3.Searching for Patient Participants & gaining consent to interview	1								
4.Interviews A & B/ 1 & 2	1								
5.Interviews C & D/ 3 & 4	1								
6.Interviews E & F/ 5 & 6	1								
7.Interviews G & H/ 7 & 8	1								
8.Interviews I & J/ 9 & 10	1								

June – December 2011 will be used to transcribe, code and analyse all data from interviews and questionnaires. January – June 2012 will be used to write up research and finish the first draft of the thesis. Results will then be available for participants and the service providers. It is planned that results of the research can be published in a peer review journal in 2014.

CHAPTER 6

DATA ANALYSIS & STUDY RESULTS

6. INTRODUCTION TO CHAPTER

Chapter six will be presented in two parts: the data analysis and discussion of the results in relation to the theoretical framework. This is necessary to show transparency of data analysis according to the six chosen headings and utilise qualitative extracts so that the reader has confidence in the conclusions drawn from the study. The results in the second part of this chapter will relate directly to the six headings derived from Comfort theory (Kolcaba, 2010), the bio-psycho-social model (Engel, 1977) and the literature review. These were physical, psychological, social, environment, age discrimination and loneliness. It is the factors involved in the ability of the patients to achieve relief, ease and transcendence (Kolcaba, 2010) in each category which is extracted from data, explored and compared.

It is acknowledged that imposing a theoretical structure could possibly hinder other themes from emerging, but as explained in chapter three the thesis premise is nursing and to remain patient-focused so the purpose is not to discover e.g. NHS finance issues and examine organisational theories. The author feels satisfied that the theoretical context can be defended as a piece of nursing research. Chapter seven is also a results chapter which specifically pertains to the interpretation of findings to answer the research questions mentioned in chapter one.

It was decided because the theme of loneliness has social and psychological effects to insert it under these category headings. Also, age discrimination has social and environmental effects, so this theme can be examined under these headings also. Any participant remark regarding ageing effects on their capabilities will come under the physical heading. Therefore, for ease of analysis the final four categories used to analyse the data are physical, psychological, social and environmental and the two additional themes of age discrimination and loneliness discovered in the literature review, are highlighted and incorporated into these categories so they can be discussed within their context.

Kolcaba (1994) tells us that patients experience comfort needs in stressful health care situations and that these needs are assessed holistically in four contexts of

patients' experiences. These are the physical needs pertaining to physiological problems and sensations due to diagnosis and psychospiritual regarding awareness of self, meaning to one's life and relationship to a higher being. Also, social needs in relation to family and society, and environmental needs regarding the external background to human experience such as noise, temperature, natural versus synthetic elements. These four comfort needs were adapted to suit this study along with incorporating the bio-psycho-social model (Engel, 1977).

It is not only necessary to utilise the four main categories of physical, psychological, social and environmental to analyse data, but to ascertain how relief, ease and transcendence were achieved by patient participants within each of these categories. This results in three areas to examine within each of the four categories and so, helps unfold how comfort needs were met for each individual patient. In summary, in this chapter multiple case study analysis will be presented in relation to the four categories, two themes from the literature review and a table presented to depict how comfort needs were met in the four categories areas by way of relief, ease and transcendence (Kolcaba, 2010).

Therefore, part one explains the data analysis and part two depicts the analysis as applied to data to expose the results of the study. This is structured in part two as the following:

1. Unit of analysis tables of matched injury containing the group of patients and staff who assessed them.
2. Qualitative extracts and discussion pertaining to the four headings of physical, psychological, social and environmental.
3. Tables relating to how the patients reach comfort in respect of relief, ease and transcendence. This is important as there may be a successful recovery from injury but it is the comfort experiences along the way in the four headings that will expose the positives and negatives of each care pathway such as what helped or hindered recovery.

6. PART I: ANALYSIS OF DATA

6.1 Introduction

The method of data analysis has been discussed in chapter five. This enabled exploration of each individual case, to compare and contrast between cases, different settings, staff members and groups. The objective of the data analysis was to fulfil Yin's (1994) application of the case study method of describing real life context in which interventions have occurred, to describe the intervention itself and explore the intervention outcomes.

The theoretical propositions are the six areas that will act as a guide to help keep focus in analysing the data and the case study protocol as advocated by Yin (1994) is essentially the research questions that need answering. Exploring the six headings in the data analysis ultimately determined how successful intermediate care was in delivering an alternative service at home as opposed hospital. Therefore this multiple case study reveals the real life context of the phenomenon of intermediate care.

6.2 Sample Population

Chapter five described how the patient participants were located in the A & E department with the aim of matching two same/similar injuries that took opposing paths of care at home or hospital. It was also discussed how the investigator used a matching table to keep track of the injuries to search for in both groups in order that ten patients were found comprising of: five patients who went home with an injury matched with five patients who were admitted to hospital. This equalled five pairs of two matched participants.

The completed table when all participants were identified is shown below (Table six). In total there were four falls with no bony injuries and six fractures of varying limbs. During the five months of data collection there was no set idea of what type of injury was required other than being able to match them by destination. Although it was previously evidenced that intermediate care, especially delivered in the home environment, worked best for people who had suffered falls or fractures (Brooks,

2002). The last two patients enlisted were after a week of waiting to see if the injury arrived at A & E and if they would give consent to participate. The interviews were then arranged and undertaken.

TABLE 6 - MATCHED INJURIES

HOSPITAL	HOME
FALL (no bony injury c/o back pain)	FALL (no bony injury c/o back pain)
FALL (no bony injury)	FALL (no bony injury c/o head injury)
≠ UPPER LIMB (humerus)	≠ UPPER LIMB (humerus)
≠ LOWER LIMB (patella)	≠ LOWER LIMB (patella)
≠ LOWER LIMB (malleolus)	≠ LOWER LIMB (malleolus)

The sample population of patients comprised of eight females and two males. The sample population of staff comprised of nine females and one male. The age range of patient participants was 72-89 years old, mean age 80.5 years which depicts an older population. Staff age range 39-58 years old, mean age 48.5 years. All participants were of white British ethnicity. Three patients in the sample group previously had negative experiences of staying in hospital and were incidentally in the home group to be interviewed. This information about the participants was not known prior to interview or selection and had no impact on the clinical decision-making by staff.

Using the case study method the patients and staff participants are referred to as the case units of measurement. Even though this study incorporates analysis of individual cases it was seen from the methodology the need to group these cases in a multiple unit. For the patients that went home or stayed in hospital a staff member would have assessed them as to where was the most suitable setting for their continued care to take place. Therefore in an effort to triangulate data sources as recommended by Yin (1994) and Walsh (2001) the staff members were also included in the study, giving a total of 20 cases.

It was discussed in chapter five what a multiple case unit (Diagram three, page 121) comprised of: paired patients and the staff members who assessed them equalling four cases. The advantage of this is being able to draw not only comparisons

between a hospital and home patient, but also between the staff members who assessed them from an organisational perspective and to help fill in any data gaps if the patient did not understand why their care took place in a particular setting. The qualitative data presented in this chapter will take this format of a multiple unit consisting of four cases. Qualitative extracts are also included to help the reader contextualise the lived experience.

6.3 Thematic Analysis

A coding frame is where data are organised and coded to allow the key themes to emerge and to be retrieved at a later date. The coding method can then be applied to the whole data set. The repeated reviewing and sorting of detail-rich data are integral to the process of analysis in the case study approach (Crowe et al. 2011).

The first process of data analysis involved reviewing each individual transcript for the four categories and two additional themes using different coloured highlighter pens. The written transcripts were analysed for a sentence or statement regarding a particular category. For example, if a patient mentions their inability to climb stairs and the problems this created in moving furniture downstairs to sleep, then this would be coded 'environmental'. Once this was complete it was necessary to extract each case's statement per theme in order to group together findings. This second analytic process allowed for identifying any recurrent themes such as six patients felt lonely. These recurrent themes identified from the findings would make apparent results as a whole which would link to the theoretical propositions or protocol.

By utilising the coding method it enabled qualitative statements to be extracted that would illustrate each individual participant's journey of care and pathway to comfort in terms of relief, ease and transcendence. Therefore, it was necessary to be mindful of any positive or negative statements made under each of the six headings such as factors that helped or hindered recovery. Examples of these are waiting times, carer response times, length of service or stay and provision of equipment. A highlighter pen was used to identify any factor that helped or hindered attainment of comfort in the categories.

The next step in the coding process was to explore transcripts for any reference made to the research questions. A different coloured pen was used again to highlight any comments pertaining to service, performance or resource issues. For example, a staff member may comment on delays with transfers of care, the multi-disciplinary team input and resource issues. The results of these findings are presented in chapter six.

Table seven below demonstrates the qualitative statements extracted per category. After the first two coding processes to analyse data, a few key words were used to represent a statement under a category heading. In other words, common statements had common themes such as family support and communication under the social heading. This enabled a summary of findings to be presented in the table below of the main topics that were issues under the components of holistic comfort of physical, psychological, social and environmental. This table helps the reader visualise a summary of emergent themes which have been organised according to the theoretical framework.

TABLE 7 – CORE CATEGORIES

	PSYCHOLOGICAL	PHYSICAL	SOCIAL	ENVIRONMENT
THEMES	Perception of coping	Impact of injury	Family support	Location of injury & hazards
	Vulnerability	Recovery time	Communication	Infection risk
	Loneliness	Understanding of injury	Status	Noise
	Effect of changing wards	Adaptations/ Equipment	Withdrawal, cost and timing of care	Equipment accessibility
	Unhappy/happy with care	Co-morbidities	Staff support	Furnishings
	Previous experience	Pain	Activities of daily living	Privacy

Tellis (1997) refers to functional equivalence where the same variable may be measured by a variety of different indicators all of which have some bearing on the concept. From the above table it can be seen how statements made by participants on a particular topic fitted into one of the four categories, for example, furnishings

with environment, loneliness with its psychological effects, impact of injury with physical effects and family support in the social heading. Thus, deconstructing of statements has taken place and reconstructing in the form of grouping clusters of key words within each theme heading. These brief factual statements help the reader summarise the findings as to the extent of the care impact on all participants.

To indicate where these themes have emerged from data in the transcript extracts in this chapter they are further broken down into individual key words or concepts. These are: *burden, coping, independence or dependence, disengagement or re-engagement, family, recovery, pain, equipment, finance, frailty and disorientation*. Part two will illustrate the complex relationships between categories, themes and concepts. Key theme words are presented in italic type, also 'age' related themes and 'loneliness' are in italic type. The four main categories are in bold type. After each participant account a table will be presented to depict how 'relief, ease and transcendence' have been achieved by each participant.

Yin (1994) describes the explanation-building process as producing an account about a case by identifying causal links, undergoing an iterative process (such as theoretical interpretations or comparison of cases) and finally returning to the propositions of the study. Chapters six and seven will show the coding and explanation-building process and these explanations or theoretical interpretations, will be related back to the aims of the study and the implications for practice of its findings in chapter eight.

Yin (2003) also advocates maintaining a sceptical approach when analysing data and to seek out any rival explanations, rather like a detective investigating a crime where there may be alternative explanations as to why the crime occurred. The researcher must acknowledge alternative explanations that do not match with the original line of inquiry, which will increase the reliability and transparency of the study. In this study the main rival explanation that occurred was regarding the high incidence of loneliness experienced by six of ten patient cases.

The data seemed to suggest that loneliness occurred as an unintended consequence of care and injury impact on functionality. However, upon further examination several of the patients and two staff members commented on the norovirus occurring at the same time for hospital patients which restricted visitors. Therefore, an alternative explanation for the feelings of loneliness could be the lack of family visiting made the patients feel isolated. Loneliness will be explored later in this chapter.

A need that was mentioned by one participant was her companionship with her cat, which strongly influenced her desire to have care at home as she did not want to leave him. This potentially is another theme that may warrant analysis in a study of older people's experience of companionship and it was not a theme that was expected to occur. For the sake of maintaining focus this theme of pet companionship is not explored in great detail, but rather presented in the qualitative results to show reality of the patient's lived experiences.

6. PART II: RESULTS

6.4 Multiple Case Study Results

This next section will show how the four categories derived from Comfort theory (Kolcaba, 2010) and the bio-psycho-social model (Engel, 1977) have been applied to each transcript. Each unit of measurement contains four cases (two patients and two staff) as previously explained totalling five sets of multiple cases. The four themes are highlighted in bold type by any matched statement made by the participant that links to a particular theme. The theoretical interpretations of the themes will also be transparent through the investigator's general analytic approach of explanation-building as described by Yin (1994).

To help with understanding each of the five units of study a table has been presented for each one containing the matched injury. The participants were given a letter or number during the coding process. However, it is easier for the reader to relate to them as 'real' people having 'real-life' experiences if they are given pseudonyms. Therefore, the names given to the participants in this section are fictitious to protect their anonymity. Key theme words will be presented in italic type, 'age' and 'loneliness' related themes are also in italic type. The four main categories are in bold type. After each participant account a table will be presented to depict how 'relief, ease and transcendence' have been achieved by each participant. Lastly a summary of findings will be presented.

Unit of Analysis 1: Matched Injury –
Patient who had fallen with no fracture but suffering back pain
Home Patient - Mrs Atkins
Hospital Patient - Mrs Alderson
Assessor of Home Patient - Nurse Alexander
Assessor of Hospital Patient – Nurse Aitcheson

Physical –Mrs Atkins feels she had a bad experience at A & E after suffering a fall with no bony injury. She had hurt her back and arm and as her hand was swollen the nurse tugged her rings off and she felt this caused a broken finger so is now seeking compensation. Not directly witnessing the event or being involved in it the

investigator felt it was unwise to comment on the event, but was sympathetic to the patient's *pain* she had experienced. **Psychological**-Mrs Atkins was willing to talk during the interview about her home care from ERS only and would not have wanted to stay in hospital unless absolutely necessary. She admits she did worry about how she was going to *cope* at home.

Well yes, there's nothing much wrong with this hand.
(Physical) I can't do a lot with this hand, so this hand, I'm flummoxed (Mrs Atkins).

Social -The occupational therapist visited Mrs Atkins whilst at A & E and discussed having help at home (*dependency*).

Yes she said Mrs they'd already sorted out nurses to come. But they finish now on Friday, so how am I going to manage after Friday, I don't know. I mean I am managing to dress. I'm washing dishes with one hand, well not washing them properly. I can manage in the shower, well not really, there are parts of the body you can't dry unless you got 2 hands... so if they stop Friday there is nothing I can do about it (Mrs Atkins).

I asked if a referral to social services had been made for continued help after ERS finished as they are only supposed to be a ten day service at this point in time. Mrs Atkins explained that a social worker had been to assess her ongoing needs.

No, no, no, they wants £10 and I'm not paying it...I am not having enough money. I get my mobility which goes for my transport. I get my care allowance I have to payout for cleaning 'cause I can't do it myself due to my back. I got a surgical corset here that I use... I've been having carers for nothing (ERS) but now I have to pay. I pay for someone to take me out as I suffer with panic attacks and I can't go out on my own. I haven't been able to go out for nearly 30 years. I've given a list of how much money I've got left every week and it's, I think it's £8.98 or £8.89 one or other and they want £10 out of that (Mrs Atkins).

Unfortunately, Mrs Atkins cannot afford a payment toward any further help social services can offer (*finance*). Although it is anticipated that her hand and exacerbation of back *pain* since the fall will settle in the coming weeks (*recovery*), the lack of ongoing care is clearly bothering her (*dependency*). Due to duty of care and ethical practice this lady would not have been abandoned if the nurses and therapists felt it was unsafe for her to be at home without any support, but she is making efforts to

wash, dress and feed herself. This move towards *independence* would have been part of the ERS input for her. I asked about voluntary agency input as the community teams work closely with organisations such as *Age Concern* who can help patients for up to six weeks following hospital discharge.

I'm waiting for them (*Age Concern*) to come see me. They referred me, but I'm still waiting, they may be able to help me (Mrs Atkins).

Age Concern can offer services such as shopping, cleaning and befriending so will be able to continue to support her after ERS pull out. Also, the money saved in not paying privately someone to do her shopping for six weeks could go towards the social services cost of care £10. **Environmental**-It is unclear what care this £10 involves or whether she could have had a shower call twice weekly with money saved from the help of the volunteer service. It is possible that this lady could have *coped* without any service input and was just anxious to be left alone home with no support.

I had a bad experience in hospital so was glad to be able to come home, carers have been great, shame it isn't longer. I know that it is a new service to help you. It's only for a certain time (Mrs Atkins).

Social –Mrs Atkins said that she has children and grandchildren but they all work and are busy and doesn't like putting on her *family (burden)*. She also would not want her son to see her body if he assisted her to shower. Nurse Alexander when interviewed explained the situation regarding her care.

She has appreciated the carers going in, but it has been difficult to extract ourselves now she is getting better. She is not prepared to pay for social services care so we have referred her to a voluntary agency that can help her and we will pull out as soon as they start. She is doing a lot for herself now, but still finds it difficult due to the *painful* hand. She has a follow-up appointment in the hospital this week to check her progress (Nurse Alexander).

Physical-According to Nurse Alexander because Mrs Atkins did not suffer a fracture as a result of her fall and the *pain* could be managed with analgesic tablets she was suitable to go home with ERS input. Nurse Alexander did confirm this lady believes

she suffered a further injury to her finger whilst in A & E and was seeking legal advice. This was a separate care episode in which ERS were not involved.

TABLE 8- Mrs Atkins' Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Analgesia for back and hand pain	Immobilisation of hand	Undertaking activities with one hand
PSYCHOLOGICAL	Reassurance and support	Knowing that her needs could be met by carers	Overcoming financial worry with ongoing support from Age Concern
SOCIAL	Carer assistance with daily activities instead of family	Family could visit without the burden of care	Can still pay a friend to take her out whilst receiving help until she has physically recovered
ENVIRONMENTAL	Hospital admission avoided	Can attend outpatient appointments	Home equipment provided, helped to shower and assisted in the kitchen for meals

Social-Mrs Alderson had similar thoughts on not being a *burden* to their family.

I wouldn't have been able to *cope*...I wouldn't have been able to *cope*. I needed that break from it all 'cause I was going non-stop myself for the 15 years that my husband died. Doing everything: the shopping, the washing, cleaning, standing at the bus stop, all that I had to do, it all myself, so I got the shopping so I didn't put anybody out, when I was able to. It was hard. The body didn't want to do it anymore... I was grateful for the time I was there, the rest it helped me (Mrs Alderson).

Physical-Here Mrs Alderson refers to her perception of *coping* ability after the fall experienced and how she needed the break in hospital as physically she felt her body was not *coping* anymore- *Age (dependency)*. There is also an element of lack of help in her words that she does all these tasks by herself but is now having difficulty (*frailty*). **Environment** -It appears due to the *pain* she was experiencing she felt it was appropriate for her to be admitted to hospital rather than go home.

I was in too much *pain* to come back here (home)...I took the morphine they gave me which was alright, but it was *painful* for quite some time, about 10 days, especially at night when I used the bedpan. You know the nurses were, well that was *painful*, well then they started giving me the commode and they said, well it was just too *painful* to be lifted and exhausted after that, and lifting me up as well (Mrs Alderson).

Mrs Alderson went onto explain that visiting was stopped whilst she was in hospital due to the outbreak of diarrhoea and vomiting. **Psychological**-I asked if she found the lack of visitors hard to *cope* with. She replied,

Yes, there was nobody for anyone. It was an awfully long day... I couldn't communicate with anyone. They must have been in their 90's. Lovely people, but I couldn't communicate with them, so good job I had the papers. The nurses were really marvellous with them, you know, the care they give. I'm glad to be home now, but I thank them for all they did for me (Mrs Alderson).

Social –Mrs Alderson is describing above her experience of being a patient and as there were ill and *frail* patients in the beds around her who could not communicate, she felt *lonely* during this period. Her *coping* mechanism for this was to read the papers to occupy her time but obviously she was observant of the work going on around her to talk of the nurses' care of the other patients.

Environment –Since coming home Mrs Alderson had to make adjustments to the way she lives by moving downstairs as she finds the stairs difficult (*frailty*). The occupational therapist put *equipment* in such as a commode and has arranged for it to be emptied daily. Also a physiotherapist had given her a walking frame in hospital to take home.

I'm happy downstairs, I don't think I'm ready for the stairs yet, I don't think so, I don't think so. I know my body so well, that I wouldn't dare take a chance, even getting the milk in I am frightened of falls (Mrs Alderson).

Psychological-Mrs Alderson is still suffering the psychological effects of the fall in that it has affected her confidence in mobilising outside her home and up the stairs (*recovery*). The term 'post-fall syndrome' has been used (DH, 1999c) to describe the

loss of confidence and voluntary restriction on activities after a fall that can be out of proportion to the physical injuries sustained (Parry et al. 2001). It is part of the physiotherapist role in the ERS team to help regain this confidence by supervised exercises in the patient's own home.

Environment -She believes this is her ultimate goal to climb the stairs when she feels stronger and would like to visit the ice-cream parlour near the sea front (*re-engagement*). Therefore, she is aware of her limitations but has hopes of regaining her confidence and physical ability in the weeks to come (*recovery*). For Mrs Alderson the hospital admission was definitely needed at the time of the fall due to her *pain* level and decreased mobility. She was very appreciative of the care she received in hospital and the only negative comment was regarding her feelings of *loneliness*.

Physical- Pain being the reason for the hospital admission is supported by Nurse Aitcheson who assessed her.

She wouldn't have managed if she hadn't of stayed in. She needed the stronger analgesia which wouldn't have been available in the community. She couldn't have administered it herself and nobody could have done it in the community. She needed to be in to receive the stronger analgesia and be monitored. She needed maximum assistance for the first few days (Nurse Aitcheson).

Even though this justifies the admission it does bring up a potential service issue. The ERS nurses are competent or can be trained to give strong analgesia like morphine. **Environment**-However, it would be considered a risk factor in the community environment to give such medications intravenously if *disorientation* or respiratory depression could occur (British National Formulary, 2011). Also, ERS do not provide a 24 hour service to monitor the patient if they suffered drowsiness as a side-effect and they would be at greater risk of falling in their home. Therefore, this admission was justified in order to deal with the pain issue in a safe environment.

Social-Even though Mrs Alderson was interviewed regarding her hospital experience Nurse Aitcheson explained that there was a delay in finding social care capacity for someone to call to empty her commode so she could have gone home earlier (*dependency*). Being deemed medically stable ERS did pick up this lady until social services could take over, but she had to wait a week for them to have capacity. Thus, this lady was a delayed discharge due to social care capacity which is another resource issue. However, Nurse Aitcheson said that if ERS had not picked her up she would have remained in a hospital bed several weeks waiting for social services to pick her up. **Psychological**-Nurse Aitcheson believes that Mrs Alderson was involved in all decision making,

Yes, patient-centred care. She would have been consulted about everything and involved in all decisions. We feel the patient was happy with all arrangements... she did suffer *loneliness* as norovirus was here so no visitors. We had to keep her spirits up (Nurse Aitcheson).

TABLE 9 – Mrs Alderson’s Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Strong analgesia for back pain	Maximum manual handling assistance at the beginning	Undertaking minimal activities at home
PSYCHOLOGICAL	Keeping spirits up when lonely	Reading papers when patients around her could not communicate	Using distraction and occupying her time by her own initiative
SOCIAL	Assistance with daily activities whilst in hospital	ERS supported discharge to bridge social services care package delay	Setting goals for social interaction in the community such as visiting the ice-cream shop and not being a burden to family
ENVIRONMENTAL	Hospital care was needed due to pain level	Ability to be supported at home in a downstairs existence	Journey towards regaining confidence by setting goal of climbing stairs and using a walking frame around home

In the extracts of the first multiple case study presented it can be seen that the themes in Table six under the headings of psychological, physical, social and environmental are present. Similar themes in both patients' account are their perception of *coping* alone, not wanting to be a *burden* to their families but prepared to accept help from other services (*dependency*) and *pain* affecting their physical capabilities. Service issues that have emerged are the length of time the ERS service can provide care for, analgesic administration in the community and *financial* assistance. Also social care delays in starting care packages. Thus available manpower and costs affect both the health and social care delivered.

Unit of Analysis 2: Matched Injury – Patient who had fallen with no fracture but suffered a head injury
Home Patient - Mrs Brown
Hospital Patient - Mrs Biggins
Assessor of Home Patient - Nurse Baxter
Assessor of Hospital Patient – Nurse Bell

Social-Mrs Brown was very reluctant to stay in hospital.

I got my cat see love. I wouldn't have wanted to leave him. He keeps me going and I look after him. Only would have stayed in if it was life threatening or something because of my cat I love him and couldn't bear the thought of him being left here alone (Mrs Brown).

Mrs Brown was very *independent* and had initially declined any services to help her when she left A & E. **Physical**-She did not let the fall affect her confidence. However, due to the severity of the fall she had agreed to a nurse assessment at home as she still had sutures in her scalp (*recovery*) and it was feared she may still be at risk of falls- **Environmental**. Nurse Baxter explains what would have happened if Mrs Brown had taken the opposite care path and had stayed in hospital-

Psychological.

I think it would have hindered her *recovery* because she would have become quite distressed because previously she'd been to A & E and um they wanted her to stay in and she declined. Because of her cat and she loves her cat and she refused to stay. So if she was made to stay she would have been quite psychologically affected. It would have been quite a damaging effect to her health

really, so it was quite positive that ERS could go in. That she could come out and they could go in to help (Nurse Baxter).

Social-Mrs Brown said that she felt she did not need the carers after a few days,

They helped me with washing and dressing and meals, but I am *independent* and was fine washing myself after a few days. They just do the commode now and my bed. I got meals delivered, but I try and do a little something for myself in the evening (Mrs Brown).

Environmental-Nurse Baxter states that it was evident that *equipment* was needed in the home and the occupational therapist from intermediate care was able to come out quite quickly and deliver a perching stool, a raised toilet seat and a bed lever to help maintain her *independence* at home. **Physical**-Also the physiotherapist gave her a walking frame which helped her to mobilise safely around her home.

Social-Mrs Brown relies on the help of a neighbour to do her shopping and she had friends who take her out (*dependence*).

I've only been out once since it happened. I got two good friends and I will be going out more. I like to go down to Mumbles for the day. I don't have any *family* to help, but I'm very *independent* anyway (Mrs Brown).

Nurse Baxter said from her initial assessment it was this lady's goal to become *independent* again and to go out, so with ERS input and being able to mobilise safely with a frame it has added to her quality of life (*re-engagement*).

She has achieved these goals even though she will need ongoing care for emptying the commode and making the bed... I think this was a success story (Nurse Baxter).

TABLE 10 - Mrs Brown's Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Scalp sutured and analgesia taken	Skin care and healing of wound	Strengthening walking ability by provision of frame
PSYCHOLOGICAL	Reassurance that her care could take place at home	Knowing that she could be with her cat companion	Returning to her role as carer to her pet and regaining independence in

			activities
SOCIAL	Carer assistance with daily activities and friends continued with shopping	No family, so the support network she had already remained intact	Setting goals of going out socialising and being able to maintain independence
ENVIRONMENTAL	Hospital admission avoided	Able to have equipment to help her in her own environment	Been outside once to socialise so far

Social-In the case of Mrs Biggins she was an *independent* lady but over the last year with her health deteriorating (*frailty*) she struggled to *cope* with being a carer to her husband who suffered Parkinson's disease- Age.

Well everything happened last year and that's why I had to put my husband into a nursing home I couldn't look after him no more when I've been ill myself. But since being on my own I hate it...I was in *pain* before I actually fell that might have had something to do with it. I had one of those, you know, when everything going off, I was out the kitchen and I just fell onto my side and rolled over onto my back...but then I started to have terrible *pain* so the doctor came and sent me in. It was something to do with my kidneys (Mrs Biggins).

Physical-Mrs Biggins confided that she had not long had an operation for cancer of the bladder and it was a kidney and urine infection that made her feel so unwell the day she fell.

Nurse Bell said it was quite evident due Mrs Biggins' *pain* level, fall and medical history that she would stay in for tests and treatment. She needed antibiotics, analgesia and further investigations.

I gotta get a camera you know and cystoscopy. Whilst I was in hospital for several days they washed my bladder out or something (Mrs Biggins).

Mrs Biggins was asked how she felt at A & E and replied,

Oh I didn't think I'd be coming home. I was in awful *pain*, *pains* in my back, my head, *pains* all over from arthritis

(*frailty*), but nothing like that *pain*, it was terrible. I'm glad I haven't had that back (Mrs Biggins).

Social-She was also asked what would have happened if she took the opposite care pathway and was sent home from A & E. She said,

Oh no. I was on my own. I wouldn't have been able to *cope* at all and my friend next door isn't all that well either... but my husband has always been here when I come home from hospital. On my own I was frightened. Frightened to even go in the shower. But guess what now. I've been in the shower already and washed my hair by myself. I thought I was going to fall see (Mrs Biggins).

Psychological-It is clear that Mrs Biggins had temporarily lost her confidence in mobilising due to the fall (*dependency*).

This lady was mobile and self-caring prior to admission even though she was *frail* and had health problems. With the infection treated and the care she received in hospital she has regained her confidence. It was important to her that she could still go out via taxi to visit her husband every day in the care home (*re-engagement*) (Nurse Bell).

Mrs Biggins was asked about her experience in hospital.

Well the staff were lovely, but they were short-staffed sometimes, so I did have to get into bed by myself at that time I could hardly move my legs or nothing, but they were good. And the food, much better than when I was in before. We had soup and sandwiches for tea and some nice dinners... on one day we had a real chicken breast and another day we had a pork steak, yeah it was alright (Mrs Biggins).

Social-Mrs Biggins has identified a service issue of the ward being understaffed and sometimes having to get herself into bed when she felt like she needed help (*independence: recovery*). She is complimentary about the food.

She was assisted to wash and dress, but then gradually done it herself with a bowl when her *pain* level decreased. She was seen by physio' in hospital to assist her walking with a frame (*equipment*), but she didn't need it upon discharge and had progressed back to her stick (Nurse Bell).

TABLE 11 – Mrs Biggins’ Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Analgesia, antibiotics and bladder wash	Investigations performed and subsidence of pain	Ability to get self in and out of bed and wash when pain subsided
PSYCHOLOGICAL	Frightened to be alone, so glad was in hospital	Reassurance that medical problems surrounding fall were being investigated	Confidence to return home and look after self
SOCIAL	Hospital provided social support she felt she no longer had at home	Knew she had to regain independence to be able to manage at home alone	Well enough to visit husband in a care home via a taxi
ENVIRONMENTAL	Hospital admission needed due to pain level	Hospital able to meet needs of investigations and extenuating factors of fall	Now recovered she is able to shower self in home environment so has regained confidence

In the extracts mentioned above we can see the themes presented in Table seven emerge. There are similarities between the patients in how being *independent* is important to both, although Mrs Biggins’ confidence was more affected than Mrs Brown’s. There is also an element of *loneliness* and companionship needed; one with the cat and the other with the husband. It was due to the underlying health problems and *pain* level that Mrs Biggins had to stay in hospital. Whereas it would have been difficult to gain consent from Mrs Brown to stay in due to her need to care for her cat unless it was an emergency. Therefore, having ERS input psychologically benefitted Mrs Brown and being admitted to hospital for short period benefitted Mrs Biggins to be treated and get over the fall psychologically.

Unit of Analysis 3: Matched Injury – Patient who had fallen with upper limb fracture of humerus

Home Patient - Mr Cavell

Hospital Patient - Mrs Crawford

Assessor of Home Patient - Nurse Clark

Assessor of Hospital Patient – Nurse Charles

Mr Cavell describes the incident that led to a fracture.

I fell in the study. I tripped over something and knew immediately I'd broken my right arm. My right arm was totally useless. I couldn't get up off the floor, so I shouted for help and we had the lady who does the cleaning in the house, so um my wife is elderly and disabled and she couldn't help me much. Anyway, so I was rolled over onto my back and sat up and err the ambulance was sent for... Fortunately there was immediate attention at A & E and of course it had to be x-rayed and all the rest of it and then they got a proper picture of the thing. They give me a temporary cast and sent me home (Mr Cavell).

Physical-Mr Cavell was followed up in fracture clinic and he was alarmed to find out his arm was fractured in three places and upset that he only saw a registrar and not a consultant. It was doubted whether this was related to *Age discrimination* and more likely that the Registrar was the doctor on duty assessing patients at that time. Mr Cavell said they have been getting a second opinion and the arm should have been put in traction as the bones were not healing in the proper place (*recovery*).

Psychological-Mr Cavell had been assertive and sent a fax to the consultant hoping to get some further treatment (*independence*).

Mr Cavell comments on past health experiences.

I do not trust the National Health Service, I've had experiences of different health services as I lived 35 years in Canada and what you see in Canada and what you see here are chalk and cheese...what is wrong with the NHS is it's a government system. It does not exist for treating patients. It exists to support a damn great bureaucracy, living off the fat of the land for its own damn purposes. And anything that is actually to do with useful treatment is more or less an accident. That's an exaggeration to a degree but that's the way I see it and that's my experience too (Mr Cavell).

Environmental-Mr Cavell explained that when he had an operation in the past he contracted MRSA in the wound and successfully won a case against the NHS. Thus he does not have much faith in the NHS as a care provider and said that he would definitely not have stayed in hospital and that his wife's grandparents had the attitude that hospitals were a place to die. This can be interpreted as an *age-related* statement if people previously went to hospital at the end of their lives. However,

Kast and Rosenzweig (1985) state that dramatic developments in technology and medical science in the twentieth century revolutionised the role and function of hospital as a place of treatment, not a place to die.

Social-Mr Cavell explained that the only circumstances he would have wanted to stay in was if he was going to be a significant *burden* to his disabled wife or if he could not physically get out of there-*Age (frailty: dependency)*. Mr Cavell has extensive qualifications and enjoyed an accomplished career as a Professor in Mathematics. He had very strong views about organisations,

Patients are the excuse for it being there. That's the way round it is. That is socialism. I know what socialism is. I was as pink as they come in my youth. Organisations don't exist to do a job; they exist for their own purposes... and the politicians they go along with it... makes them seem popular and attract votes, then they will sell that bill of goods to the public (Mr Cavell).

The interview was directed back to his experience of home care. **Environmental-Equipment** was already in the home from a prior back problem. **Social**-Mr Cavell did find the carers helpful at his home, but within a week had stopped them coming as he felt he was strong enough to manage his daily activities again (*independence*).

Physical-The only negative experience Mr Cavell experienced during this episode of care was the ongoing issue of the bone healing of the fracture (*recovery*). He had no complaints about the ERS service and found it helpful at the time that he needed them for, but did point out that as a service it was just another organisation.

Nurse Clark when interviewed explained that Mr Cavell was a very intelligent person on some issues. **Psychological**-Also, that Mr Cavell had previously had poor experiences of NHS care which resulted in a compensation pay out. Obviously, these prior experiences helped inform the opinions he has in the present. Nurse Clark explained that Mr Cavell was a very *independent* person and when he felt he could *cope* he did not want the carers anymore, but was kind and appreciative towards the carers whilst there. **Physical**-Mr Cavell stopping the carers coming after several days because he felt strong again could indicate he was in good physical health for his *age* apart from this recent injury.

TABLE 12- Mr Cavell's Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Analgesia for arm pain	Immobilisation of arm	Assertiveness in gaining second opinion regarding bone healing
PSYCHOLOGICAL	Relief that he did not have to stay in hospital	Knowing that his needs could be met at home and he could be with his disabled wife	Regaining his independence by stopping the carers
SOCIAL	Carer assistance with daily activities at home	Was not a burden to his wife	Utilising social skills and knowledge to be his own advocate for his health within organisations
ENVIRONMENTAL	Hospital admission avoided	Equipment was already in place at home	Able to recover at home and use home as base for communications regarding his health such as faxing

Mrs Crawford has no recollection of arriving at A & E after her injury as she was unconscious. **Physical**-Nurse Charles explained that Mrs Crawford had suffered a fall but was extensively investigated at hospital due to the unconscious episode and it was found that she had suffered a myocardial infarction. It was unclear whether the heart attack caused the fall that fractured her arm or if the heart attack happened after the fall. Therefore, Nurse Charles felt that this admission to hospital was justified due to the unconscious episode and the abnormal blood results which indicated a serious event had occurred.

Most of Mrs Crawford's memories are of the ward where she stayed.

Well the doctors and nurses were ok. They work hard, I understand that. It's not their fault. The lack of money in the NHS. They do their best (Mrs Crawford).

Social-Mrs Crawford is talking from an insider point of view of what she observed whilst on the ward of how busy staff members were and possibly the lack of staff

resources when referring to money (*finance*). Mrs Crawford said that she could not have *coped* if she had come home and felt that she had come home at the right time but is still finding some things difficult (*frailty: dependency*).

It's my right arm. Can't do much. And this heart attack. It's the second one. I'm frightened, but grateful, could have been worse. I could not be here (Mrs Crawford).

Mrs Crawford had carers upon discharge followed by *Age Concern* support. Nurse Charles stated that Mrs Crawford initially needed help with washing and dressing and was seen by an occupational therapist, a cardiac rehabilitation nurse and physiotherapist whilst in hospital. Mrs Crawford also had the support of her *family* to help with the weekly shopping, meals on wheels service and was looking forward to the hairdresser visiting her home. **Psychological**-Mrs Crawford did talk of the *loneliness* of the lack of visitors in hospital due to the norovirus similar to Mrs Alderson. Nurse Charles stated that Mrs Crawford got upset on a few occasions due to this and needed comforting, as she was an in-patient over the Christmas and New Year period. This resulted in a delay in social services picking up her case.

Environment-Nurse Charles commented that ERS should be more available throughout the hospital and not just concentrated at A & E. **Social**-Nurse Charles felt that more staff are needed at ERS to expand the service and offer more places to patients, which will help free hospital beds occupied by those waiting for social services care packages. Nurse Charles also made the comment that it is not just therapists who should be involved in referring to ERS but more nurses and especially ward managers.

TABLE 13 – Mrs Crawford’s Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Analgesia and investigations carried out with appropriate treatment for fracture and myocardial infarction	Cause of ill health found and treated along with arm immobilised	Undertaking activities with one arm
PSYCHOLOGICAL	Relief to be alive after second myocardial infarction	Comfort and reassurance given for	Felt she come home at right time to be able cope with

	and unconscious episode	loneliness	little assistance
SOCIAL	Carer assistance with daily activities during hospital stay	Returning home to own social network	Assurity that her social network of family help and hairdresser intact. Also that a service could provide her meals
ENVIRONMENTAL	Hospital admission necessary due to unconsciousness	Investigations and appropriate assessments such as cardiac rehabilitation nurse could take place swiftly in hospital	Easing of loneliness when returned to own home environment

Unit of Analysis 4: Matched Injury – Patient who had fallen with a fracture of a lower limb

Home Patient - Mrs Doyle

Hospital Patient - Mrs Dudley

Assessor of Home Patient - Nurse Daniels

Assessor of Hospital Patient – Nurse Duncan

Physical-Mrs Doyle had the unusual experience of falling whilst at her daughter's home in Kingston Upon Thames. She hurt her knee and was taken to hospital where she received an x-ray and had a plaster cast fitted. She was taken back to her daughter's house for a few days and then to her home in the research locality. She attended fracture clinic at the A & E department and was referred to the Early Response team for help at home as her daughter was only able to stay a few days to help her (*family*). Mrs Doyle explained that she did not have to stay in hospital, but would not have had any objection to it if the doctor felt it was necessary.

Environment-Upon asking her how she would have *coped* if she did not have the carers at home she said that she would have had to go hospital or for respite.

Mrs Doyle describes how the carers helped her at home (*dependency*).

She had to wash me first. I couldn't go into the shower. Although my shower is separate now and I had a shower this morning, but I had to lift one leg in. She used to wash my back and get me my breakfast... I am having appetito

meals. I had one lunchtime. I'm keeping them on, so if I am not terribly well. I don't have them at weekends, but I have them 3-4 times a week and they are quite good, but they don't do sandwiches (Mrs Doyle).

Mrs Doyle was now past six weeks *recovery* and the carers had stopped coming and she was seen by the Early Response Service's physiotherapist and occupational therapist. **Physical**-She was now wearing a brace on her leg and walking with a zimmer frame (*independence: equipment*).

I have two frames. I gave one back. Oh I got a few grabbers... I got a thing on a toilet seat, well I got something at side of bed (bed lever) but I don't use it... I have three pillows. I don't like lying flat I find it easier to sit up, there's a wireless at the side of me. My daughter bought it for me. I quite like it. Sometimes I go to sleep with it still on, but I listen to, is it radio 5? (Mrs Doyle)

Psychological-This again could point to some *loneliness* experienced, enjoying the sounds from the radio especially late at night. **Social & Environmental**-This patient chose to live in a bungalow so that stairs would not be an issue for her as she got older - *Age* and had already set up a support system to help her with various chores prior to the fall.

I've got a cleaner to help me. She comes once a fortnight, yes, she's a scream... She likes her own mop, her own hoover, she has a little red car, yes, once a fortnight she comes...And I have a window cleaner. He's quite a good man as I used to get a chair and clean that (pointing at the window). He always cleans that and inside my kitchen. I dare not get up there. Lucky I live in a bungalow. It's great when you think about it (Mrs Doyle).

Mrs Doyle is aware of her capabilities and has obviously done her own risk assessment of the activities she can and cannot do at home- *Age (frailty)*.

Mrs Doyle says she experienced no discrimination or negativity towards her because of her *age*. She felt she received all the care she needed and is reassured that she has a pendant alarm now which she can press in an emergency if she falls again. Mrs Doyle could not suggest any improvements with the Early Response Service saying,

I found the carers very kind to me. I don't think I've had a row with any of them. Sometimes I'd say, oh c'mon I think my leg should be better than that. But I found them all, well, I'd say which ones that, and one came from...
(Mrs Doyle)

Mrs Doyle has mentioned that more than one carer came to her home and sometimes felt frustrated at the progress of injury healing- *Age (recovery)*. A lot of the carers work part-time so interchange with each other, but if possible the service tries to have as few as possible per client so a therapeutic relationship can be built.

Psychological-Mrs Doyle's goal is to drive again which indicates her motivation towards *independence* and to *re-engage* in social activities- *Age*.

I was driving Christmas time last year, you see, it's just when I fell on Boxing day, I couldn't drive. Well you can't drive in a cast can you? I did ask the doctor and he said yes I can drive again. I'm having it serviced next week and luckily its automatic so I'm only using one leg. But I am *independent*. Taxis are not bad here, but not cheap. I don't know the price of petrol. Haven't put any in the car. He'll fill it up when he does the service Monday (Mrs Doyle).

Environment-Nurse Daniels explains that Mrs Doyle was safe over a 24 hour period so was able to be cared for at home with help washing, dressing and with meal preparation (*dependency*). Also, that *Age Concern* had done her weekly shop and a little bit of cleaning for her as she lived alone. **Physical**-Nurse Daniels did explain that the nurse assessment and ongoing visits were useful as medical problems were picked up.

She had problems with her medications as well over the first few days. The GP went in as her blood pressure was low, so he stopped them and re-introduced them, so she needed monitoring... This lady also went to Hot Clinic (to be reviewed by the Intermediate Care Consultant). The first date clashed with her fracture clinic appointment and the second date she went. Just to make sure she was ok because of her BP. So I thought she may have had one of those heart episodes, so wanted her checked out. There was no obvious reason for her fall at first. May have been a trip or could have been her BP (Nurse Daniels).

It is important to the ERS team to discover why falls happen. The underlying reasons, for example, due to medications affecting the blood pressure can be reversible and so prevent future falls in the older person. Having blood pressure problems and the need for medications to control it can represent *age-specific* health problems. A hospital admission can be avoided if underlying conditions are treated and future falls do not occur.

Environmental-Nurse Daniels felt that without the support at home that Mrs Doyle could have got “stuck in the system”, and if she had gone into hospital, “she’d have ended up in a residential home and never come home to be honest”. Therefore, having ERS input enabled a return to her home environment and positively discriminated against her to give another option of care- *Age*. Nurse Daniels said that gradually Mrs Doyle done more and more for herself until she just needed prompting (*independence*). When asked if there is anything that ERS could have improved upon in relation to this lady’s care Nurse Daniels said,

I suppose she could have had 3 calls a day. Because of where she lived and travelling time, the care workers... we didn’t have the care workers to provide that. Her neighbours were quite good. She had the hairdresser calling, so there were quite a lot of people back and fore (Nurse Daniels).

Social-This again indicates the social network that this patient had set up within her own community and everyone seemed helpful. Also this points to the demand upon ERS as they have limited staff numbers and have to spread the provision of care by care workers across the research area’s urban and rural areas.

TABLE 14 – Mrs Doyle’s Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Plaster cast fitted	Immobilisation of limb	Medication review able to solve cause of fall of low blood pressure
PSYCHOLOGICAL	Relieved can have care at home	Therapeutic relationship with carers and radio for company	Successful return to independence and social network boosted her

			confidence
SOCIAL	Carer assistance with daily activities	All the social support she had set up such as hairdresser, cleaner, gardener could continue uninterrupted	Attaining goal of driving car again
ENVIRONMENTAL	Avoided institutionalisation in the form of hospital or residential placement	Equipment at home such as frames, bed levers, grabbers etc	Co-ordination within her adapted bungalow of running her daily affairs and activities

Physical and Environmental-Mrs Dudley suffered a fall when she was throwing nuts for the birds on her lawn. She slipped on the icy path and did not attend A & E until the next day where they found she had suffered a fracture. Mrs Dudley was admitted to hospital due to the complex fracture. It was found the fracture was not healing with just a cast in place so she underwent surgery to help reunite the bones back together with screws (*recovery*). Unfortunately the bones still did not mend correctly and she underwent another operation over the Christmas holidays, and was discharged a few days later. This is another patient who had problems with bone healing which can be related to the *age* of the person.

Mrs Dudley believes she had no choice due to repeated operations to stay in hospital (*dependency*). **Environmental**-She remembers an occupational therapist seeing her in hospital and arranging for *equipment* to be delivered to her home before her discharge. She has found the perch stool helpful in her kitchen and is getting around at home via a wheelchair at present. Mrs Dudley has no complaints about the way she was cared for at hospital except the repeated stress of the operations. Although, she was not happy about the way she was discharged,

I was disappointed about the way I was discharged. Anybody could walk in and out there. My *family* took ages to find a wheelchair. Nobody came to help taking me out of the ward and to the car. I had to wiggle to get in car. There was no porter. I was frightened, conscious of my foot getting banged. It was a heck of a job to get me in the house. Looking back I should have stayed a few days more and had an ambulance home but there were none

available 'cause of the snow. I came out before that virus stopped all the visiting (Mrs Dudley).

Psychological-Mrs Dudley said she felt part of the decision-making so she probably thought she would be well enough to travel home via *family (independence)*. Also with an extended stay due to additional surgery she was keen to go home and not wait until the snow had gone and the ambulances were operational again. However, this does not outweigh the responsibility of staff to arrange an escort to take her in a wheelchair to the main exit which would have been helpful in this case. There was no evidence to suggest she did not get escorted from the ward upon discharge because of her *age*.

Mrs Dudley comments on her hospital experience.

It was very good at the hospital. The food was terrible, but I would say about 80% of the staff were good. The others, not much patience. Sometimes you would wait a long time if you needed the toilet, but I understood there were other patients to see to. The Philippino nurses were really good and knew their job down to a T. They're particular about cleaning and it's important to feel clean. They checked me for bed sores too. It could have been worse I could have ended up with a third operation if they put another screw instead of a plate the second time. Have to weigh it all up and a third operation would have made me lose all my confidence (Mrs Dudley).

Social-Mrs Dudley is again giving us an insider perspective about being in hospital. She revealed that she had to wait to go to the toilet because staff members were busy with other patients (*dependency*). **Physical**-A lot of elderly people also suffer continence issues and it can be frustrating and embarrassing for them to rely on others to help with such a personal need- *Age (frailty)*. She compliments the care of the foreign nurses and it was important to her self-image to be clean.

Psychological- The operation setbacks affected Mrs Dudley's confidence, but she feels this could have been worse if she had to have third operation.

Nurse Duncan says Mrs Dudley needed help with washing, dressing and toileting whilst in hospital (*dependency*). **Physical**- The complex fracture warranted the hospital stay and the need for surgery.

It was the amount of *pain* she was experiencing upon trying to walk that brought her to A & E the following day after her fall. It is unfortunate that she has had to undergo two operations due to the bones not knitting together properly. There was no option of going on the other care pathway, she had to be admitted. Her concern was that of her older husband for whom she was carer (*Age*) and if she could drive again. I believe this is her long term goal to drive again and to progress to a walking stick. She has a supportive *family*, a paid cleaner (*finance*), *Age Concern*, meals on wheels and will be having physiotherapy as an out-patient. She was part of the decision-making process. There was already *equipment* at the home when OT assessed her (Nurse Duncan).

TABLE 15 – Mrs Dudley’s Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Analgesia and operations	Avoided third operation by having a plate	Eventual bone healing and walking with a stick
PSYCHOLOGICAL	Reassurance and ongoing support due to second operation	Worry over her husband alleviated by going home	Ability to set goals and suggest improvements to hospital stay
SOCIAL	Carer assistance with daily activities during hospital stay	Able to be in the role of carer again	Setting goal of being able to drive again
ENVIRONMENTAL	Hospital admission necessary due to complex fracture and two operations	When toileting needs were addressed promptly	Equipment at home, services provided such as meals on wheels, ability to walk around home and attend outpatient physiotherapy

Unit of Analysis 5: Matched Injury – Patient who had fallen with a fracture of lower limb
Home Patient - Mrs Elton
Hospital Patient - Mr Evesham
Assessor of Home Patient - Nurse Elliot
Assessor of Hospital Patient – Nurse Errol

Mrs Elton describes how she fell.

Yes I had a fall in the bedroom. I think my foot was probably dead. Yes it was and I fell on the floor. My foot was *painful*. I rung my son. He was insistent I went to hospital, so he took me to hospital and I seen the nurse. But when I was waiting to see the doctor two women came up to me and said we'll see you later and asked if I was living alone. I said yes. Well after seeing the nurses, I saw the doctor, well between it all I waited for six hours. I was hungry and cold. Eventually I saw the doctor who said I'd broken it. I had to go back and wait for a soft plaster then I had to keep it straight... I couldn't get in my son's car, so now I couldn't get home. Luckily there was a gentleman there who said he had a private ambulance that goes for patients with blood transfusions, anyway those two men got me in there with great difficulty as I was in a chair and they dropped at the front door. I got in and my son (*family*) brought the bed down stairs (Mrs Elton).

Physical-Obviously after sustaining a fracture, the limb is usually immobilised initially to allow healing to take place and only being able to weight bear on one leg caused Mrs Elton difficulty (*recovery: dependence*). It is reassuring that the private ambulance was able to take her home. It appears Mrs Elton was treated equally in A & E with no special regard to her *age* in respect of waiting times. She had to wait several hours along with other patients; however they may not have experienced feeling cold and hungry as she did. **Environmental**-The two women who spoke to her were a district nurse and occupational therapist who arranged ERS to assess her at home and had provided a commode for her to use at home (*equipment*). They would have advised her to sleep downstairs until she was able to weight bear on the affected leg.

Mrs Elton in response to the question of how she would have felt if she had to stay in hospital replied,

I wouldn't, no I wouldn't. I'm sorry there are too many bugs in hospital today to go and stay in hospital. I

would have only have stayed in if absolutely necessary. My daughter died of MRSA whilst in hospital, so if I can stay out of hospital I will (Mrs Elton).

The facts of the daughter's care circumstances are not known (*family*).

Psychological-Obviously this past experience of losing a loved one in hospital has greatly affected Mrs Elton's attitude to staying in hospital.

Mrs Elton was pleased to have care at home.

So then the next day they came to see me the nurse and OT saw me. They sorted me out. They raised my chair. They raised my bed. I'd got a commode. I was amazed at the service I got from those people. I didn't expect it and they said they would look after me for ten days. The first week was perfect. They washed my back... I did wash my personal things...they made food in the beginning (Mrs Elton).

Social-Mrs Elton was appreciative of the help at the beginning but was disappointed when the carers stopped giving maximum support (*dependency*). Due to having ten days input only, the carers try and move from maximum assistance to minimal assistance to supervision of daily activities like washing, so the person will be able to reach *independence* before they withdraw. The only negative comment made by Mrs Elton was when there was a mix up of days to call because she had arranged a hospital appointment and said she told the carers not to call but they still turned up.

With Mrs Elton's plaster due off imminently (*recovery*) she decided not have a follow-on care package as her sister had one and the carers would turn up at all different times and not the times she usually eats (*independence*). This could highlight a potential problem for the older adult in that they may be entitled to social services help due to their *age* but have little choice in the timings of carer calls and have to accept their scheduling. She said that the ERS carers had to come at certain times but in all fairness they had tried to oblige her.

She had *family* support and her son called in every morning to make sure she had breakfast and made sandwiches for her lunch. Her daughter-in-law would do an

evening meal for her, but she anticipated doing all for herself very soon (*independence*). **Environmental**-Occasionally she likes to take a taxi into the local town and have lunch as a treat (*re-engagement*). She has also achieved her goal of climbing the stairs with the shoe that was provided for her (*equipment*).

Mrs Elton felt that this fall has not affected her confidence.

But I either sit here or get up and get out. I've been depressed, but... I'll get on with it now... only one paracetamol I had yesterday. I don't like relying on drugs (Mrs Elton).

Psychological-Mrs Elton was determined to get back to her pre-fall functioning. Despite her *age* she was motivated to be active again, *independent* and not rely on medications. Nurse Elliot states that from the assessment of this patient,

I think it was her confidence and this lady was lucid, very *independent*. So her needs were to prompt with things like washing and dressing and monitor her mobility around the home and make the place safe as well and monitor her *pain*. Straight away I requested an OT assessment and apparently the bed was too low for her and the chair was too low for her. She was having difficulty with transfers, so the ERS OT went in to raise the bed and chair which made a lot of difference to her mobility (*equipment*) (Nurse Elliot).

Environmental-Nurse Elliot felt it would have been inappropriate for this lady to be admitted to hospital when she could be cared for at home. Nurse Elliot said that this is what the patient wanted and it suited her needs. Also that having this input at home led to a quicker *recovery* for the patient in her opinion.

ERS helped her on her journey to get back to relative *independent* state... about 15 days input she had. Started with two calls a day then reduced to one, because she was going outside for lunch and the carers would turn up sometimes and she wasn't there. Only problem outstanding for her was emptying the commode during the afternoon. She wanted it done at a certain time so now the physio' has done stairs with her we're hoping she will use the toilet upstairs (Nurse Elliot).

Physical-It appears that within a two week time frame ERS managed to make good progress with helping Mrs Elton almost back to her former level of functioning.

TABLE 16 – Mrs Elton’s Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Analgesia and soft cast fitted	Leg immobilised	Progression to a shoe to aide mobility. In control of own analgesia.
PSYCHOLOGICAL	Care could be given at home as lost a loved one in hospital	Exertion of control of times of carer calls to suit her	Achieving goals of climbing stairs and going out maintained her confidence
SOCIAL	Carer assistance with daily activities at home	Family support regarding meals	Ability to take a taxi into town for lunch
ENVIRONMENTAL	Avoided hospital admission and had provision of equipment at home	Able to temporarily live downstairs	Achieving goal of climbing stairs and going outside

Physical-Mr Evesham suffered a fall in the kitchen after he felt his leg give way (*frailty*).

Well I did think I'd stay in I know I broke my leg, so I knew I would need time to *recover*, but I was in four weeks. The *pain*. The ambulance gave me morphine. After 4 weeks I was sent to another hospital for physio' on my hip and developed problems passing water. It was very embarrassing. I lost a lot of weight. So I had *recovered* from my hip but had to stay in for two months. I've got to see a specialist now in a few weeks about passing water, they tried, but I still needed catheter (Mr Evesham).

Nurse Errol explained that it was unfortunate Mr Evesham developed complications which started with constipation affecting his ability to pass urine. This lead to a longer hospital stay and when the long-term catheter was removed he could pass urine by self-catheterisation. He did have urinary problems prior to this hospital stay which could indicate a physical decline in functioning due to his *age*.

Social and Environmental-Mr Evesham saw the physiotherapist and occupational therapist whilst in hospital and was able to wash and dress himself after his first four week stay (*independence*).

Yes they put *equipment* in for me, this hallway, the handrail for my toilet and a raised seat. The height of my

chair and my bed... I got a friend who helps me with shopping and *Age Concern* helped with cleaning... I use a frame and put things in the caddy and slowly I am able to polish again, using this. I am getting there slowly. At the moment having meals on wheels. Been helpful... I can now do it. My porridge or cereal. I got it all worked out. I can do it now myself, washing and shaving (Mr Evesham).

Physical-Mr Evesham had previously suffered a stroke on the same side as his lower limb fracture (*frailty*). He felt that this made mobilising difficult, but with a frame (*equipment*) he could get around his home, but did not expect to be able to go outside (*re-engagement limitations*). He felt if it were only bruising that he had suffered instead of a fracture that he would have come home and would have wanted to come home, but knew due to the fracture he would have to stay in. Nurse Errol agreed with this that in the circumstances with the fracture and *pain* level he had to be admitted to hospital.

Environmental-Commenting on his hospital experience Mr Evesham said,

It was good. I must say the nurses I found very good. On the whole they were ok... I would have liked to stay in one hospital instead of two. Christmas eve I was moved from one to another. I understand they needed bed. But I knew everyone and they could talk to me. Different on the new wards. Not many could talk to you. But fair do's the sister made me feel welcome on Christmas day... The doctors were very good and explained things (Mr Evesham).

Psychological-*Loneliness* and not being able to communicate to other patients was also an issue for Mrs Alderson and Mrs Crawford. In Mr Evesham's case it was the move to another hospital for rehabilitation that affected him psychologically and timing of it on Christmas Eve (*disorientation*). **Environmental**-Nurse Errol says this was unfortunate timing as the pressure for beds was great and the hospital was probably trying to avoid moving people on Christmas day. Nurse Errol says that Mr Evesham was very motivated to recover.

Mr Evesham said,

I'm grateful. It's my *independence* I'm determined to get back... I had antibiotics... I'm happy. I can get dressed and make a sandwich... I don't want to fall again. I have good neighbours. I have brothers (*family*) but they live away, so a friend helps. My friend comes down every day, catches bus, even in snow, helps with shopping, has a chat, everyday. Good friend to me he is (Mr Evesham).

Social-Mr Evesham like some of the other participants had already set up a support network of a friend and neighbour prior to the fall and it seems their help after the fall has proved beneficial to aide his *independence*.

Nurse Errol describes the multi-disciplinary effort needed to get this patient home.

This patient had full support with OT, physios, carers, *Age Concern* and meals on wheels. It was a multi-professional effort upon discharge. Otherwise he would still be in hospital as he would not have been safe to come home without support due to his mobility problems and the need to self-catheterise (Nurse Errol).

Environmental-It appears then that therapy input from ERS at home and during hospital stays are very important to ensure a safe level of functioning and to maximise *independence* in the patients' own environment. Therapists' input regarding discharge planning and therapists' assessments upon discharge have been important to issue the necessary *equipment* to enable safe transfers and mobility around the home and helps daily activities such as toileting. Nurses have to possess an awareness of the therapists' roles as they are usually the first to assess patients and identify the needs in relation to *equipment*, mobility and daily activities of living, based on the functional level of the person after they have suffered an event which affects their health.

TABLE 17 - Mr Evesham's Comfort Needs Met

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Analgesia, operation, antibiotics and catheter	Physiotherapy and no longer needing catheter	Ability to physically move around his home with frame and undertake activities
PSYCHOLOGICAL	Nurses and doctors	Being made to feel	Understanding of

	reassurance and information	welcome on the ward on Christmas day	bed pressures and happiness at being able to return home
SOCIAL	Able to communicate with some patients on a ward where he stayed	Multi-disciplinary effort for discharge including age concern and meals on wheels	Did not want to achieve going out. For his friends to continue their support and visits.
ENVIRONMENTAL	Relieved to be in hospital due to fracture and urinary problems	Therapists adapted home with equipment	Achieving goal of undertaking activities in home environment like polishing and shaving

6.5 Summary of Findings

To aide summarising findings in relation to the four categories which represent attainment of comfort a synopsis has been presented below on each category. This also demonstrates the explanation-building process of a general analytic approach to the multiple case study data as described by Yin (1994). Following this will be a discussion on drawing together the factors involved in achieving relief, ease and transcendence that has been found in participant accounts.

6.5.1 Physical

Pain was a good indicator to the patient whether they had to stay in hospital or not and how they would perceive they could *cope* with their injury in carrying out the daily activities of living. Also, the kind of *pain* medication needed as Mrs Alderson needed morphine which was considered a risk factor to give at home due to its side-effects of syncope and disorientation (British National Formulary, 2011). This could have resulted in a greater risk of falling in the home environment, particularly as there was no 24 hour supervision.

The falls suffered affected a limb whether it was fractured or not, which impacted on patients' self-care ability. Without the ability to care for themselves like washing, dressing, and meal preparation all the participants needed help for varying levels of *dependency*. Hospital and home patients were assisted with decreased mobility by

physiotherapists and *equipment* like a zimmer frame as an aide towards *independence*.

Brooks (2002) revealed the common reasons for referral to intermediate care were falls and needing assistance with activities of daily living. This is also true for this sample. Donnelly and Dempster (1999) support this saying the most success with care at home is with patients who have suffered fractures. Other physical factors mentioned by the hospital patients were the physical complications of their *recovery* such as Mrs Dudley needing further operations and those not associated with their initial injury such as Mr Evesham who suffered urinary retention.

6.5.2 Psychological

The falls which caused the injuries affected the patients' confidence in different ways. Some were not affected and wanted to attain *independence* as soon as possible and others were very frightened and needed the therapy input to slowly regain their confidence. Examples of lack of confidence in home patients were the ability to climb stairs or take a shower which links to suitability and safety of home environment as explored by Utens et al. (2013). Thus the *coping* ability was very individual to that person.

Loneliness

Psychologically six out of ten patients suffered loneliness. Five patients in hospital felt lonely due to the lack of relatives visiting during the norovirus and being moved to different wards. One patient felt lonely at home because she missed her husband's support when she was unwell, as he was residing in a care home. This is a high percentage of the sample population.

There is a rival explanation to loneliness of extenuating circumstances of the norovirus which inhibited relatives visiting, so it is not known if the hospital group would have experienced loneliness to such an extent. However, for one patient, Mr Evesham, being moved to different wards made him feel lonely, so change of environment and resultant *disorientation* was a factor. Molley et al. (2010) found that an emergency admission made people feel lonelier rather than a planned, so it is

important for patients who have to move wards that they are given adequate explanations and time to prepare for the move to decrease anxiety. The timing of being moved on Christmas Eve could have exacerbated this participant's loneliness and another participant's loneliness could have been exacerbated by being in hospital over the Christmas period (Mrs Crawford).

The home patient's (Mrs Biggins) loneliness already existed due to missing her husband prior to the fall and affected her confidence to *cope* at home without him being there. Steed et al. (2007) found that women suffered more loneliness at home than men. For the hospital patient, Mrs Alderson, being able to proactively do something about it like occupy time by reading, supports Pettigrew and Roberts' (2008) claim that people do have some control over it and Graneheim and Lindman's (2010) claim that it can be turned into a positive experience. The companionship with a pet cat was an important factor in Mrs Brown's determination to be treated at home, and loneliness would have exacerbated by this separation if she had to stay in hospital.

6.5.3 Social

Some patients suffered a feeling of loss when care was slowly being withdrawn and worried how they would *cope*. They got used to receiving care at home and hospital. The patients had different levels of *family* support and a lot of the patients were very conscious of being a *burden* to their *family*, for example Mrs Alderson. Hallberg and Kristensson (2004) highlighted the need for *family* to be involved in the home care plan and ERS carer assistance was designed around what *family* help was already received for some participants like meal provision. Some preferred having help from a stranger whose job it was to care than bothering their *family* who were busy working and raising families. Mrs Atkins highlighted the cost of care that they would have to contribute to an ongoing care package after ERS input finished (*finance*). However, they went on receive help from a volunteer agency, Age Concern.

The social care needs identified by the sample group were toileting, meals, washing, dressing, cleaning and shopping. It was found that one patient, Mrs Alderson, needed assistance with activities such as using a bed pan at night in the hospital

environment which ERS could not provide during the night in the community. An interesting finding was that some participants had already set up some type of social network of assistance at home which they were keen to *re-engage* with. For example, having a friend or neighbour do the shopping, gardeners, hairdressERS, cleaners and friends taking them out for lunch (Mrs Brown, Mrs Doyle, and Mr Evesham).

Therefore, this group of older people had adequately prepared for a gradual decline in functional ability as described by aging theory (Hughes, 1995) which was exacerbated during this injury episode. Negative social comments made were Mrs Dudley having to wait for the toilet in hospital because staff members were too busy (*dependency*) and the delay in setting up a care package for Mrs Alderson's discharge to empty a commode at home. Mrs Alderson's findings supports evidence presented in the literature review by Baumann et al. (2003), Regen et al. (2008) and Coffey (2006) of delays in transference of care between health and social services. The social theme can also be linked to loneliness in the psychological theme as it lack of social support of *family* or ability to undertake activities that caused loneliness for some participants.

6.5.4 Environmental

Equipment was needed in all cases from provision of a zimmer frame to raising chairs and providing commodes. Safety of environment was considered where the obstacles at home for Mrs Brown and going home post-head injury she could have suffered dizziness and been at high risk of falling again. There were various authors in the literature review that claimed that care at home reduces the risk of re-admission. No patient was readmitted in the home or hospital group during the data collection period. It can be seen from participant accounts how important and rapid the occupational therapist response to provide *equipment* and safety advice at home was. This supports evidence by Nancarrow (2004, 2007) and Wade (2004) where team working and decision-making by the multi-disciplinary team ensures the success of the service.

The main reason whether care was delivered in a certain environment was *pain* level in this sample. The *pain* suffered from the injury, its complications or the need for complex treatment such as operations or further investigations determined the most suitable environment for care to be delivered. This links in with the concept analysis on intermediate care in chapter two on what this middle area can provide, as opposed secondary or primary care. One patient (Mrs Alderson) needed physical assistance with activities such as using a bed pan at night in the hospital environment which ERS could not provide during the night in the community.

The perception of home for all participants was their own familiar surroundings that they wanted to get back to as soon as possible. However, there was recognition by some patients and staff members that they would be unable to *cope* at home with their injury without assistance or a hospital stay. For example, Mrs Atkins admitted to worrying about how she would *cope* at home without help and Mrs Alderson realised she had to stay in hospital because she judged she would not *cope* at home in the state of functioning and resultant *dependency* she was experiencing at that time.

6.5.5 Age Discrimination

No patient mentioned any age discrimination and all felt part of the decision-making process. Therefore, this sample group did not experience any negative discrimination directly related to age as described in literature review by authors such as Davis (2010). This can be interpreted as an advantage to the availability of intermediate care because it gives older people another choice to have care at home, as long they are involved in that decision and do not feel forced into it. However, Nurse Daniels commented that Mrs Doyle could have been institutionalised into a residential home if ERS did not exist and this may not have happened to a younger person. One patient had to wait several hours in A & E with no special regard to her age or symptoms of cold and hunger, so was treated equally. One patient was displeased they were assessed by a registrar instead of the consultant, but there was no evidence to suggest they were prejudiced against due to their age.

Five out of the ten participants mentioned having Age Concern's help in the community after ERS had finished their input due still requiring lower level needs such as shopping and cleaning. Age Concern is charity to help improve health and social services for the older adult and they have now joined forces with another charity, Help The Aged, to become Age UK (Age UK, 2013). The charity's vision is for individuals in later life to be treated as equal citizens which links to the theme of age discrimination within the literature review, also for older adults to have enough money for a decent life which was relevant for one participant in this study who could not afford ongoing care (*finance*), Mrs Atkins, so the charity helped instead. The charity's vision makes reference to the entitlement of a safe, comfortable home which links to the environmental category in this study and for older adults to have opportunities to participate as an active citizen in society which links to the social theme. Driving and going out were important social activities for some participants to *re-engage* with.

In this small sample size of ten patient participants all felt they were in the appropriate setting for their needs. Therefore, it appears that older people are being positively discriminated against to receive alternative care at home. Also, with the availability of Age Concern support as step down care provision post-ERS input, which would not be available to younger people. The next chapter will explore as a category how the aging theory relates to this sample group of older people in terms of physical, psychological and social effects.

6.5.6 Attainment of Comfort through Relief, Ease and Transcendence

It has been learnt that holistic comfort care encompasses the four themes of physical, psychological, social and environment. Through achieving comfort in these four areas the patient has moved towards attaining wellness and *independence* after an injury. Epstein and Borrell-Carrio (2005) explained that elements such as these are not a linear hierarchical level theory but rather a web or matrices of elements. Therefore what may be important to one participant, like the psychological effect of loneliness, may not be important to another where the physical healing (*recovery*) may be important. It is necessary to examine the participants' accounts to ascertain what elements of holistic care were important to their recovery.

Physically, two patients had prolonged hospital stays due to the physical injury or another illness. It has been seen that the physical element of resulting incapacity of a limb had a knock on effect on the other elements of being able to *cope* psychologically in an environment with daily social activities. Therefore, the physical event is the instigator of knock on effects on the other elements and is interrelated with them. Relief, ease and transcendence were achieved in this element mostly by *pain* relief and assistance at varying times for the participants.

Psychologically patient participants experienced a fear of being unable to *cope* and six experienced feelings of loneliness. Relief and ease were met with provision of care assistance, staff reassurance, *family* support and for two patients, their ability to have some control over their psychological state of loneliness in undertaking alternative solitary activities. Thus, professional and personal support, along with their inner resolve and creativity eventually helped participants move towards transcendence as described by Kolcaba (2010).

The social element is interrelated with both the physical in terms of the activities the patient needs assistance with due to the injury and psychologically the experience of loneliness or lack of social stimulus. The availability and timing of care provision was important for both hospital and home patients and the patients experienced discomfort in the form of frustration until these needs were met. There were varying levels of *family* support, but a common theme was patients not wanting to be a '*burden*' on their *families*. The data analysis revealed how the patients had already set up networks of support to assist them with daily activities like hairdressers, cleaners, and gardeners and those patients were keen to *re-engage* with this support.

Environmental comfort for this participant group involved having needs met in a timely fashion, for example one had a long wait for toilet assistance in hospital (*dependency*), the level of assistance provided in the environment and the safety of that environment. Assessment of safety took various forms from falls risk assessments, removing obstacles at home to providing *equipment* to aide manoeuvrability at home such as toilet and chair raisers, bed levers, perch stools

and the space to use a zimmer frame. Also, participants with lower limb fractures had *family* help move their bed downstairs temporarily under the instruction of the occupational therapist. Environment provides the key to deciding the suitability of where the patient can have their care.

On the one hand there is the hospital with all the *equipment*, personnel and medications available over a 24 hour period. On the other hand is supported care at home to a maximum of four carer calls a day, a doctor available during the day time and the nurse until the evening. Therefore each patient's needs were assessed against what could suitably be provided in each environment pathway. For example the patient who needed further operations and the patient needing morphine could not be treated under the present Early Response criteria at home. The patient with an incapacitated limb and no other physical complications on simple analgesia could be treated at home. Therefore, the physical component and the ability to achieve comfort in this element determined the most suitable environment.

6.6 Conclusion

The stories of the patients' journeys through the two care pathways of home and hospital have been presented in qualitative extracts of case studies and analysed. The coding process was enabled by the use of themes typed in bold. This direct link between the main themes in the qualitative evidence and the theoretical framework to attain holistic comfort has been presented. In simple terms a patient has suffered an injury producing discomfort and this impacts their functioning on a physical, psychological, social and environmental level. These four factors make up the derived components of holistic comfort care (National Institute of Wellness, 1977; Engel, 1977; Kolcaba, 2010).

In application of Kolcaba's (2010) Comfort theory these patients experienced through nursing, medical and therapist interventions relief from pain, ease in feeling helped with daily activities and transcendence in achieving goals and rising above their challenges. Ultimately, whether the patient experienced care at home or hospital, comfort for all ten patients was achieved by the end of their care journey. What has been important are their own unique paths to recovery and what has helped or

hindered along the way. It has been a closer look at these differences in pathways which reveals the quality and effectiveness of care or comfort received.

It is interesting in this small sample of ten patients that three of them had prior bad experiences of NHS care. One participant contracted MRSA during a hospital operation and had successfully sued for compensation several years ago as it left them with poor mobility. Another had suffered losing her daughter in hospital after she had caught MRSA whilst there. The third participant was presently seeking legal advice over the alleged removal of a ring from her swollen hand which she claimed resulted in a broken finger. It is obviously a random process in how the ten patients were identified to take part in the research, so the study will not be commenting in further detail about these experiences. The next chapter presents the results from the data analysis in relation to the research questions or mental framework.

CHAPTER 7
STUDY RESULTS IN
RELATION TO THE
RESEARCHER'S
'MENTAL FRAMEWORK'

7. RESULTS

7.1 Introduction

The multiple case study data analysis has been presented in the previous chapter in relation to the four categories of physical, psychological, social and environment, the two themes of age discrimination and loneliness and tables on how each patient participant achieved relief, ease and transcendence. New themes emerged through data analysis of burden, coping, independence or dependence, disengagement or re-engagement, family, recovery, pain, equipment, finance, frailty and disorientation which require discussion.

This chapter will also answer the research questions by drawing from the data of this study. Yin (2003) says that a case study protocol is optional, but it is helpful to have a set of questions for the researcher while collecting data like a 'mental framework' to maintain the line of inquiry. In chapter one the research questions were presented which are akin to a 'mental framework' which has guided the interview questions and focused the data analysis. Below is a reminder of what the research questions were:

- In light of health plans to shift more acute care to the community within the NHS care system (WAG, 2005), has the Early Response Service successfully achieved an alternative type of care available to patients in that they can be treated in their homes instead of hospital?
- What are the physical, psychological, social and environment problems this sample population experienced and how did each care pathway address these?
- Was the appropriate type of patient treated in the most appropriate environment? Are any changes needed to the criteria of who receives care at home?
- To find out how the patients feel about their care? Did they have a positive experience on the chosen care pathway? Did the patients experience any age discrimination or loneliness?
- What resources are needed to enable caring for more people at home instead of hospital? Were there any environmental issues with receiving care at home?
- How effective are the multi-disciplinary team members in care delivery and are family involved in the patients' care?

- Are there any issues with delayed discharges to care at home services? Were there any re-admissions to hospital in the sample population or were patients able to reach independence at home?

This chapter will address these questions by utilising data gathered from the study. For ease of reference some tables have been produced to help answer the research questions. In chapter eight all elements of the study in relation to the wider picture of intermediate care and the NHS will be drawn together. The conclusions and recommendations for practice will then take place.

7.2 Discussion on New Themes That Have Emerged From Data

The new themes have a commonality of the perception of coping after injury and how dependent or how much of a burden that the patient will be due to existing frailty. It is necessary to look back at the literature review to see if these themes were present in other studies. Donnelly and Dempster (1999) stated the most success with healthcare at home is with patients who have suffered fractures, which is true of this sample. This can be interpreted as the level of dependency resulting from a fractured limb can be suitable to home care. Utens et al. (2013) found that home patients during their recovery have difficulty managing daily activities. This was evident in the patient case studies where during the recovery phase patients needed help with activities. There was also evident the move from maximum assistance to minimal assistance over a period of time which depicts the path of recovery from injury to wellness or dependency to independence.

Hallberg and Kristensson (2004) advocated that the family should be involved in the home care plan. It can be seen from the data that some participants had daily or weekly family help around what ERS could provide such as shopping, cleaning and making meals. Others did not have any family help and relied upon friends or social networks they had set up to provide support. Some participants feared being a burden on their family and one commented that they knew their children had busy working lives and had their own children to look after. Age UK (2013) feels that the notion of burden fosters feelings of passivity and dependence which must be

challenged in services for older people where some can actively take part and make decisions about their care.

Cahill et al. (2009) believes there is an increasing complexity to the needs of older people which requires families to perform more care for longer periods of time. In semi-structured interviews with 50 older adults they found the feelings of not wanting to be a burden were described in terms of not wanting to complicate busy lives of children, guilt about their health problems and concern that their children were overly-worried about them (Cahill et al. 2009). Some participants in this study had specific roles for family members to undertake and others preferred strangers such as carers to help, especially with personal care. Obviously, the balance of the amount of help provided by the family and social services or schemes such as ERS has financial implications to planning healthcare resources.

It has been seen from the research findings that level of pain was one of the factors that differentiated an admission to hospital or the ability to go home post-injury. Kumar and Allcock (2008) found that pain in later life is generally accepted as normal and expected and that this must not be tolerated. They describe the effects on quality of life, dignity and restriction of activities. Kumar and Allcock (2008) found in two listening events of 21 participants that pain is more complex in older people as they have multiple co-morbidities, can be more sensitive to drugs to control pain and restricting movement puts them at high risk of pressure sores and isolation. These authors advocate adequate pain assessment for older adults and identifying the physical, social and psychological effects of pain.

One participant mentioned the financial restraint of not being able to contribute to an on-going care package fee which impacted on the level of help she would receive at home. Other participants mentioned active social lives and being able to afford private help such as gardeners, hairdressers and cleaners. Therefore, the financial circumstances of the sample group were variable. Hill et al. (2012) found that one in ten older people were struggling to afford the basics on their income. Charities such as Age UK (2013) provide free financial advice to older people and this would have

been offered to the one participant who was waiting for their assessment of her on-going needs.

Other new themes that emerged such as recovery, independence and equipment are discussed throughout the rest of this chapter. The disorientation experienced by moving wards produced temporary discomfort for one participant and links into the loneliness theme of hospital patients not being able to communicate with fellow patients, so they felt isolated. The frailty theme is derived from the effect of injury on an older adult which encompasses the physical, social and psychological effects and their coping ability. This links into ageing theory which is further discussed in this chapter.

7.3 Results in Relation to the Research Questions or Mental Framework

7.3.1. The Success of Providing Alternative Care at Home

It can be seen from chapter six regarding data analysis that care at home was successful in meeting the appropriate patients' needs and at point of assessment the suitability to be treated at home correctly identified the appropriate patients that could be helped. Therefore, the five patients who went home with the Early Response Service's help saved five hospital admissions if intermediate care did not exist. This in turn saved on secondary care resources and helps support the definition of secondary care of those needing acute care, not intermediate care. Therefore, in this sample population there were no inappropriate admissions to the intermediate care service as stated can occur by Kaambwa et al. (2008).

The benefits of the provision of an alternative care at home service is that it is cheaper (McCain, 2012) and gives the patient more options as to the most suitable environment in which to have their care. Several authors have documented how hospital can be a disorientating experience for older people and the Dignified Care Report (Older People's Commissioner for Wales, 2011) says that whether the patient has dementia or not, a hospital admission causes anxiety and stress. Therefore, the possible unintended consequences of a hospital stay such as disorientation or anxiety have been avoided by those receiving care at home.

All participants felt part of the decision-making process and in this small sample size there was no disagreement between patients and staff about which setting their care took place. However, all the patients were unaware of the existence of the Early Response Service, so it was looked upon as a relief for three participants who had bad prior experiences of hospital care that they could be cared for at home. From the data, even though care appeared successful at home, it is important to note any issues that arose during their home care pathway.

Issues brought up by patients and staff regarding the home care pathway included: facilitating access to the intermediate care consultant for a medication review, co-ordinating the provision of equipment at home and the moving of a bed downstairs, effective communication with the patient and arrangement of carer calls at convenient times, ensuring the same carers if possible so a therapeutic relationship could be built up and the issue of withdrawing care that the patient had become used to. In respect of generalisability, any care at home programmes would need to consider these issues and how they can be solved, such as transferring care to a voluntary agency like Age Concern when health needs were met and the team's input was finished, but there were still social needs such as shopping and cleaning.

For this team the provision of a multi-disciplinary service of a qualified nurse, carers, occupational therapists, physiotherapist, social worker and availability of a doctor ensured these issues were resolved. Therefore, it is interpreted from the data that a multi-disciplinary team is central to the work of the care at home service. This study has given insight into an intermediate care service through patient and staff experiences and it is these findings which help better understand care at home as opposed hospital. The data has shown assistance was provided in both settings to promote comfort and recovery from the injuries sustained.

7.3.2 How Each Pathway Addressed the Four Elements of Holism

Please see chapter six on the data analysis of the four themes of physical, psychological, social and environment to ascertain the findings from each pathway.

In summary, pain from the injury under the physical heading was a good indicator as to whether a hospital admission was necessary and the physical discomfort experienced had the knock on effect of causing issues in the other three theme areas. The severity and extent of these effects determined the most suitable environment.

On the hospital pathway stronger analgesia, night time assistance, and needing maximum manual handling assistance stood out as benefits of this pathway to meet these patient needs that the home pathway could not. Also, the availability of more acute resources such as one patient needing further operations, another urology investigations and another had suffered a heart attack. Therefore, the 24 hour care availability and having experts on hand were advantages of the hospital pathway for patients to help them meet their needs in each of the four elements. Disadvantages such as the lack of prompt response for toileting needs in hospital for one participant, Mrs Dudley, is supported by evidence (Older People's Commissioner for Wales, 2011) which found the same problem for other patients and this can result in humiliation and resultant incontinence.

The crux of the home care pathway was the provision of carers to provide the assistance in each category such as social help with washing and meals that ensured the success of meeting their needs. Also, as previously mentioned, the availability of the multi-disciplinary team's expertise. There were limitations to the home help that could be provided such as they could provide a commode and carer calls to empty it, but they could not provide a night time call or 24 hour service. Therefore, the patients' needs in each of the four derived elements of holistic care determined the most suitable pathway.

7.3.3 Suitability of Each Patient to the Two Pathways

Please read above in that the patients' needs were assessed in A & E by a professional and knowledge of service provision at hospital or home helped inform the suitability of each patient for the appropriate pathway. Therefore, it is imperative

that referrers to the Early Response Service have copies of their criteria and discuss with staff members if that patient's needs could be met in the community instead of hospital. It has already been discussed that physical injury sustained, resultant pain, complications and effects on the patient's self care abilities (social and psychological) was an important factor in determining the most suitable environment for them.

The following table looks at whether in the opinion of the patient and professional a hospital stay was necessary. If all admissions were necessary then one would not expect a home patient or the member of staff who assesses them to say they should have been in hospital. Also, for those who were admitted one would not expect a hospital patient or member of staff who assessed them to say that they should have gone home instead of being admitted.

TABLE 18 - HOSPITAL ADMISSIONS NECESSARY

		HOSPITAL ADMISSION NECESSARY
HOME PATIENTS & STAFF	Mrs Atkins	NO
	Nurse Alexander	NO
	Mrs Brown	NO
	Nurse Baxter	NO
	Mr Cavell	NO
	Nurse Clark	NO
	Mrs Doyle	NO
	Nurse Daniels	NO
	Mrs Elton	NO
	Nurse Elliot	NO
HOSPITAL PATIENTS & STAFF	Mrs Alderson	YES
	Nurse Aitcheson	YES
	Mrs Biggins	YES
	Nurse Bell	YES
	Mrs Crawford	YES
	Nurse Charles	YES
	Mrs Dudley	YES
	Nurse Duncan	YES
	Mr Evesham	YES
	Nurse Errol	YES

Table eighteen shows us that there is agreement between patients and professionals of whether a hospital admission was justified. This proves the ERS referrers and hospital teams are accurately identifying what type of patient injury and resultant extenuating factors can be cared for at home or hospital. However, it does not indicate any leeway for ERS to pick up anymore patients out of the sample population if all admissions were necessary.

The only other angle would be if ERS could pull these patients out of hospital sooner. Therefore, those who became medically fit whilst in hospital and who experienced delayed discharge could have been pulled out by ERS. During the research study, an initiative was started by ERS to do this and one ERS nurse actually did proactively pull out two of the hospital patients into the care of intermediate services at home with carer input or therapy input. Otherwise they would have had a longer hospital stay waiting for a care package from social services. Thus, it appears the type of patient having their admission prevented was working in practice, but there is more potential to facilitate early discharge.

The next table depicts the reasons why hospital admissions were necessary in the opinions of hospital patients and staff.

TABLE 19 – REASONS FOR ADMISSION

		REASONS FOR ADMISSION
HOSPITAL PATIENTS & STAFF	Mrs Alderson	PAIN
	Nurse Alexander	PAIN. NEED FOR MORPHINE.
	Mrs Biggins	PAIN
	Nurse Bell	PAIN. MEDICAL HISTORY. FURTHER INVESTIGATIONS NEEDED.
	Mrs Crawford	UNCONSCIOUS STATE.
	Nurse Charles	UNCONSCIOUS. FOUND TO HAVE HAD HEART ATTACK AS WELL AS FALL.
	Mrs Dudley	PAIN. IMMOBILITY.

	Nurse Duncan	PAIN. IMMOBILITY. NEED FOR SURGERY.
	Mr Evesham	PAIN. IMMOBILITY.
	Nurse Errol	PAIN. IMMOBILITY. NEED FOR SURGERY.

From table nineteen it can be seen the serious reasons that differentiates these patients with the other patients who suffered similar falls and fractures, but were allowed to go home. The need for surgery or having suffered a heart attack justifies the hospital admission. For the rest, the pain level requiring morphine and the level of immobility influenced the reasons for the hospital stay. Also, with one patient, the medical history of cancer discovered upon assessment and the pain level experienced, justified further investigations in hospital. These investigations would have been done urgently and quicker than if the patient had been sent home.

7.3.4 The Criteria of Early Response Help at Home

Service provision is based on the identified demand of health needs and scarcity of supply of resources available to meet that demand (Parkin, 2009). In other words, it can be seen from the evidence that provision of a 24 hour rapid response service could have enabled one participant to come home who needed night time carer calls for toileting. However, due to financial restraints this was not provided by the Early Response Service. Also, if a night call was provided within present resources it would have taken away the resources of a carer during the day time. Therefore, resources would need to be increased to widen the criteria of those who can be cared for at home. An alternative would be to link into other community teams who do provide night time calls like the continuing health teams and share resources.

By the end of this study the idea to create a Community Resource Team where intermediate care fractured teams pulled together and pooled resources was beginning to take effect. The advantage of this as advocated in the policy document (WAG, 2010) is if there are no further finances to expand resources a pooling of community resources can able services to meet demand more efficiently. Other changes in criteria could be to meet more acute needs at home like intravenous antibiotic therapy, which would require further training for the nurses in the Early

Response team and the GP or intermediate care Consultant to take responsibility of the patient's care and prescribing in such cases.

7.3.5 Patients' Positive or Negative Experiences on the Care Pathways

It is important to note if the patients were satisfied with the care they received from the Early Response Service and hospital. Also, to note any positive or negative experiences during their care journey. Table twenty depicts the patients satisfaction summarised in a simple yes or no answer.

TABLE 20 – PATIENTS' SATISFACTION WITH THEIR CARE

	PATIENTS	SATISFIED
HOME PATIENTS	Mrs Atkins	YES
	Mrs Brown	YES
	Mr Cavell	YES
	Mrs Doyle	YES
	Mrs Elton	YES
HOSPITAL PATIENTS	Mrs Alderson	YES
	Mrs Biggins	YES
	Mrs Crawford	YES
	Mrs Dudley	YES
	Mr Evesham	YES

Patient satisfaction is a general overview of the whole care pathway experienced. Even though they are all satisfied with their care it can be seen from the qualitative extracts that some were dissatisfied along the way and experienced discomfort in some of the theme headings. For example, waiting for toilet assistance, help needed upon discharge into the car, loneliness, delay in care package being set up and the alleged broken finger. Other issues that patients were dissatisfied with were length of carer input, lack of staffing, waiting for discharge and having to move hospital beds. Table twenty one contains any negative or positive comments made about the hospital or home care by both patients and staff. Also if any of the participants made suggestions on how the care could have been improved.

**TABLE 21 – POSITIVE & NEGATIVE COMMENTS ABOUT CARE
RECEIVED**

	PARTICIPANTS	POSITIVE	NEGATIVE	SUGGESTION
HOME PATIENTS	Mrs Atkins	Care was good at home.	Bad experience at A & E due to alleged hand injury caused by staff.	For ERS to give longer input. Help to pay for social services care.
	Mrs Brown	Appreciative of care at home.	Loneliness. Wanted less assistance within a few days as had gained independence.	
	Mr Cavell	Care at home helpful.	Bone healing issues. Previous bad experience of hospital care.	For NHS care in this country to be on a par with that of abroad.
	Mrs Doyle	Carers were very kind.	Loneliness. Different carers so had to get to know several of them.	To try and stick to same carer.
	Mrs Elton	Amazed and grateful for service given at home.	A & E waiting time. Previous bad experience of hospital care.	Longer input of ERS carers.
HOSPITAL PATIENTS	Mrs Alderson	Satisfied with care in hospital.	Suffered loneliness as unable to communicate to other patients.	Put with other patients you can communicate with.
	Mrs Biggins	Food was good.	Loneliness. Short-staffed so had to put self to bed.	More staff.
	Mrs Crawford	Got treated.	Loneliness. Short-staffed.	More staff.
	Mrs Dudley	Had good care overall at hospital.	Repeated stress of operations. Food terrible. Disappointed at way discharged.	More staff. Staff to assist with getting you into car when you have a cast on.

			Having to wait for toilet.	
	Mr Evesham	Had good care. Doctors were good at explaining things.	Loneliness. Having to move hospitals on Christmas Eve.	To be able to stay on one ward during length of stay.
HOME STAFF	Nurse Alexander	Able to transfer care to voluntary agency.	Difficult to extract carers as patient wanted them longer.	Expand service so can provide longer input.
	Nurse Baxter	Rapid response of occupational therapy and physiotherapy providing equipment at home.		
	Nurse Clark	Was appreciative of care at home.	Should have had the input for longer but patient felt they could cope.	Had to overcome previous bad NHS experience through reassurance for patient to accept care.
	Nurse Daniels	Medical problems picked up quickly. Able to stay in own home.		
	Nurse Elliot	Able to make home safe with equipment. Quicker recovery at home.	Carers would call and the patient would be out to lunch.	More carers so can visit at times suited to both patients & staff.
HOSPITAL STAFF	Nurse Aitcheson	Achieved patient-centred care.	Delayed discharge due to waiting for social care help.	Faster access to care packages to enable discharge. More ERS availability.
	Nurse Bell	Did not need any further physiotherapy upon discharge.	Loneliness.	
	Nurse Charles	Able to give psychological support.	Delayed discharge due to waiting for social care help	Faster access to care packages. More ERS availability &

			over Christmas period.	more presence on wards so more nurses can refer.
	Nurse Duncan	Able to be part of decision-making process.	Unfortunate, the repeated operations the patient endured.	
	Nurse Elliot	Multi-disciplinary effort to get patient home safely.	Unfortunate that suffered physical complications that prolonged stay. Delayed discharge waiting for social care.	Faster access to care packages to enable discharge when the patient is medically fit.

From the above table it can be seen that on the whole patients were satisfied with their care, whether it took place at hospital or home. Positive comments from staff centred on being able to achieve the patient care goals by a multi-disciplinary effort and involving the patients in the decision-making process. This is similar to Kolcaba's (2010) description of transcendence where patients rise above their challenges and meet their goals. Negative patient comments surrounded the delay in assisting with their daily activities such as toileting, having different carers, staffing levels and food. Thus, anything that acted as a barrier to their daily functioning needs, the help they perceived they required and achieving comfort in the four theme areas. It is interesting that loneliness appeared as a reoccurring theme for this group of participants with six of them experiencing it. Although five of the hospital patients felt lonely during their stay as opposed one who had care at home.

Negative comments by staff mostly surrounded service issues such as lack of staff in order to meet patient needs promptly. Also, the frustration when the patient was medically fit, they had to wait for social care availability before being able to discharge the patient home. Thus, staffing issues have emerged in both the hospital and home data. These two findings of delayed discharge and lack of staffing were also found by the Older People's Commissioner for Wales (2011) where they

describe a patient languishing in a hospital bed is a false economy and low staff levels affect the timeliness of response to needs.

7.3.6 Age Discrimination and Loneliness

These two issues were addressed in the data analysis chapter six but it is important to examine the case studies for anything that relates to the age of the older person. Wade (2004) states that those working in intermediate care are in an ideal position to root out age discrimination. All of the patient participants were asked if they had experienced age discrimination and none of them had. All of the staff participants said that they felt the patient was involved in all care decisions. All participants were pleased with the options of care they received, but one was disappointed that they would have to pay for continued care at home from social services. The only inference that can be made to age relevancy is the amount of hours the patient had to wait at A & E. One could argue that this can have a more significant impact on elderly people as opposed younger adults. One participant stated that they were cold and hungry. It is hoped that this patient was regularly checked whilst waiting and perhaps a suggestion could be hourly checks on older people who are waiting in the A & E seating area.

Hughes (1995) explains that there are different theories of ageing where the biological perspective concerns the pathological degenerative process of the human body. The psychological perspective concerns the decline in memory and ability to learn new skills. The sociological perspective concerns disengagement theory where the person gradually withdraws from society. It was interesting to examine the case studies to see if theories on ageing are apparent. Also, the physical, psychological and social aspects of ageing link to the theoretical context of this study. For ease of analysis, a table relating to the ten patients have been constructed below. This also helps cross-referencing between them.

TABLE 22- RESULTS IN RELATION TO AGEING THEORY

	PHYSICAL	PSYCHOLOGICAL	SOCIAL
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Mrs Atkins	Reference to hand injury causing difficulty with daily activities.	Worried about how is going to cope without carer support.	Lack of money for social services care.
		Does not want to be a burden to family.	Cannot go out on their own.
Mrs Alderson	Body did not want to do it anymore.	Loneliness and lacked confidence.	Was not able to communicate with other patients, so read papers instead.
	Needed to be lifted up and felt exhausted after that.	Fear of the stairs.	
		Does not want to be a burden to their family.	
Mrs Brown	Helped me with washing and dressing.	Did not want to stay in hospital as would miss cat.	Likes being taken out by friends.
	Needed a zimmer frame.	Wanted independence back.	Does not have any family.
Mrs Biggins	Awful pains in back and head.	Frightened at home alone without husband.	Relies on neighbour, but she is unwell herself.
	Could not move legs.	Fear of falls.	
Mr Cavell	Right arm totally useless.	Mistrust of NHS due to previous experience.	Partner elderly & disabled so could not help much.
	To be able to do physical tasks for himself again.	Hospitals are a place to die.	Has a cleaner.
Mrs Crawford	Cannot do much.	Frightened, but grateful, could have been worse.	Family help with shopping. Has meals on wheels.
	Need help to wash and dress.	Loneliness	Hairdresser visits house.
Mrs Doyle	Fell whilst visited daughter in England and has brace on leg.	Could not have coped without carers.	Has appetito meals.
	3 pillows, does not like to lie flat.	Loneliness.	Wireless at side of bed.

	Blood pressure was low so had medications changed.	Wants to drive car again for independence.	Has a cleaner, a window cleaner and gardener.
Mrs Dudley	Slipped on icy path.	Disappointed not helped into car by staff.	There were other patients to see to, had to wait a long time for help to go to toilet.
	Fracture was not healing properly.		Carer for older partner.
Mrs Elton	My foot was dead. I fell.	Fear of hospitals due to previous experience.	Son helps.
	They did everything for me.	Get up and get on with it.	Taxi to take out to lunch.
Mr Evesham	Mobility problems. Leg gave way in kitchen.	Loneliness. Affected by moving hospitals.	Friend does shopping.
	Complications with bladder control.	Determined to be independent again.	Has meals on wheels and carer input.

Although some of the evidence above is in relation to ageing, some of the statements could be made by anyone who is disabled or ill at any age. However, the statement from Mrs Alderson that her, “body could not do it anymore”, is quite age specific to how tired her body felt and she suffered arthritis. Perhaps as Hughes (1995) stated the ageing adult withdraws from society as to why so many participants experienced loneliness. However, there was the extenuating factor of the norovirus prohibiting visitors for some of the patients which as Yin (1994) explained could be a rival explanation for this.

Psychologically they did not want to be a burden to their families, so may not have told their families how lonely they felt. None of the participants mentioned a decline in memory, although some rapidly changed subject or went off the subject during the interview. None of them mentioned their ability to learn new tasks, but some mentioned their desire to drive again or go out with friends which was important for their socialisation.

Perhaps if younger people had suffered a trip or fall they would not have suffered a fracture as their bones are stronger. Osteoporosis is a decrease in bone density which affects women more than men, especially after the menopause (Jarvinen, 2008). There is an increased falls risk in the elderly due to frailty including impaired eyesight, balance and movement disorders, low blood pressure, syncope and cardiac arrhythmias (Jarvinen, 2008). Therefore, elderly people can be unwell or have co-morbidities that increase their risk of falling.

Not being able to communicate with fellow patients who were more ill than them made one participant feel isolated on a hospital ward. However, there are older people who work past retirement and run marathons, so it is not fair generalise that older people have been through a disengagement process from society with some of the participants determined to keep an active social life. The counter theory is that of activity theory where it is believed that any loss of role, activities and relationships should be replaced with new ones to ensure well-being in old age (Powell, 2001). Also, disengagement theory (Hughes, 1995) does not mention class.

The more affluent participants afforded private help and attended more social events or physical activities. Three participants had a private cleaner, gardener, hairdresser and went out for lunch. Picton (1991) argues that it is not axiomatic that old age equals a decline in social interactions and networks. The author states that it is the professional's responsibility to encourage engagement with society even it takes a different form from when they were younger, such as luncheon club or book club.

7.3.7 Resources Needed to Care For People at Home

From the sample population's qualitative accounts it can be seen that all home patients had provision of equipment at home. Equipment needed took the form of zimmer frames, commodes, chair and toilet raisers, perch stools and bed levers. The hospital group also had provision of equipment like a zimmer frame in hospital and a home visit prior to discharge to arrange home equipment. The therapists (occupational therapist and physiotherapist) were the key members of the multi-disciplinary team to enable equipment provision and safety of environment.

From a nursing perspective it was seen in section 7.3.4 how the criteria could be widened to encompass 24 hour care, to pool resources with other community teams to enable more effective service provision and how important the carers' role was with daily activities and access to the intermediate care Consultant. Section 7.3.5 table twenty presented suggestions to improve the care at home service. It was seen that more staff was a suggestion for both hospital and home patients, for the home service to be longer and to increase the amount of patients they can pull out of hospital. Thus, resources are a big issue determining the level of care that can be provided at home, but this is offset against the more expensive hospital care when an admission is saved.

7.3.8 Environmental Issues

Please see data analysis chapter six regarding the issue of environment and it has been discussed in this chapter already the importance of physical injury effects on daily functioning in determining the most suitable environment for the patient. It is interesting to note that for care to be facilitated at home safely the occupational therapist's role in the co-ordination of family bringing a bed downstairs. If a lower limb was injured the patient could not climb the stairs and had a fear of climbing the stairs. This achieves Kolcaba's (2010) goal of ensuring comfort in the home environment. Without the setting up of all care downstairs in the patients' environment then possibly they may have had to stay in hospital. The ongoing input from the physiotherapist to increase mobility enabled the patient to go back up stairs and this was a goal for the patient in order to reach transcendence.

7.3.9 The Multi-Disciplinary Team and Family Input

From the above it can be seen how members of the multi-disciplinary team each have a role to play in facilitating a discharge and the provision of safe care at home (Baxter and Brumfitt, 2008). Also in the NHS plan (2004) of health and social services working together, the dedicated social worker for intermediate care enabled joint working to occur. The social worker assessed each Early Response patient whether the short-term input from the home service was enough or if they needed referring to social services for a longer term care package to take over. This was

done swiftly to help free up the Early Response carers, so social services could take over with their care assistants.

Unfortunately, this included finances to be means tested and one patient could not afford the small contribution to an ongoing care package, so opted for the voluntary input of Age Concern. Thus, health, social and volunteer services were all working together to enable care in community to take place which demonstrates that effective links existed. It is advocated from this study's findings that any similar response team contains the multi-disciplinary members of a qualified nurse as case manager, carers, access to a medical doctor, occupational therapist, physiotherapist and social worker to enable safe effective care at home.

Regarding family input the data showed that participants did not want to be a burden on family members, but that some family members helped moved furniture and provide meals. Hallberg and Kristensson (2004) advocate that the family should be involved in the care plan. However, Picton (1991) argues that it is the time constraints with both parents having to work and care for children that can prevent them from looking after an older relative. Picton (1991) believes any social services care should complement the care that can be offered by the family, but warns that if a carer is left to cope alone they can become overstressed and breakdown if they are not given occasional relief.

Two participants were carers for their partners who had ill health, so it was important to them to make a quick recovery. One participant's partner resided in a nursing home because they could no longer cope with caring for their partner at home due to the severity of Parkinson's disease. This participant was upset about this and was determined to get back to full health so they could make the taxi journey to the nursing home to visit their partner. This participant was also frightened to cope at home alone post-fall and having the carers at home gave them reassurance about their safety.

7.3.10 Delayed Discharges

There were no significant issues with transferring care to the Early Response Service from A & E. Although carer ability and number of calls needed determined the time of the day that the actual discharge took place. Two hospital patients made comments regarding they become medically fit but had an extended stay in hospital due to waiting for a social services care package to start. It was in these two cases that ERS intervened to pull out of hospital under their new initiative of also facilitating discharge that helped get these patients home. This was dependent on their carer availability who were primarily involved in the prevention of admissions, but helped bridge a gap of service provision until the care package started. Three staff members interviewed recommended that the Early Response team's help in facilitating discharges from wards was needed due to the length of wait for care packages. This finding supports evidence by Baumann et al. (2007) on health and social care capacity issues causing delays.

7.3.11 Readmissions and Reaching Independence

There were no readmissions to hospital in the home group or in the hospital group whilst the data collection took place, so approximately over a five month period. This supports evidence that care at home helps prevent readmissions (Thompson, 2011), but also demonstrates the effectiveness of hospital care that all needs were addressed prior to discharge which contradicts Bowles et al. (2002) finding that some patients are discharged with unmet needs that risk readmission. One can speculate that a readmission was prevented by the Early Response Service in that one patient was at high risk of falls due to low blood pressure and through consultation with the GP, then attendance at 'Hot Clinic' to see the intermediate care Consultant this medical issue was addressed before a crisis occurred.

All participants achieved a regaining of independence through treatment to meet their needs in the four chosen categories of comfort care. However, a fracture can impair a limb for a long period of time after injury and recovery rates can be quite individual (Handoll and Madhok, 2008). Therefore, in relation to reaching independence it should be described in terms of meeting their goals and being able to manage daily activities without any or little assistance from services, if they had no

home care services before the injury. Also in respect of Kolcaba's (2010) comfort theory independence would be likened to transcendence of achieving goals and overcoming challenges. Thus, a patient may have a weakened lower limb but has achieved the goal of climbing the stairs which they used to do before the injury.

This gives depth to the individual lived experience of what is important to them to achieve, not complete independence with no continued care support if for safety reasons this is identified as an ongoing need. The individuality of recovery rates as explained above has complicated gaining data on exact time frames of length of time to recovery. Also, a follow-up visit and interview would have been needed. At what point a follow-up visit should have occurred would have to be estimated at for example six months, to try and ascertain exactly when and if a full recovery had taken place.

7.4 A Summary of the Findings in Relation to the Research Questions

To specifically address the research questions (mental framework) this chapter has addressed each question that was put forward in chapter one. Together with chapter six, the data results from the case studies have been presented. The following is a summary of what has learnt in this chapter.

This study has been successful in gaining the experiences of ten patients about their home and hospital care. On the whole all patients were satisfied with their care whether it took place at home or in hospital. Therefore, both the traditional routes of care and the newer route of care of having care delivery in a home setting achieved the aim of reabling the patients fulfilling comfort needs. The resources needed by both sets of patients involved not just nursing or medical care, but carer assistance, occupational therapy, physiotherapy, social workers and some participants had volunteer service's help at home. This supports evidence presented by Loonan et al. (1991) that care at home does not solely rely on qualified nurses. All participants had equipment issued promptly which helped them gain independence in their environment and lessened the risk of falls at home such as a zimmer frame, chair raisers, bed lever and commode.

The factors that were involved in recovery time were very individual to each patient. One participant was plagued by repeated operations as there was a problem with bone healing. Another developed poor bladder control which resulted in learning the new skill of self-catheterisation and further investigation. Those with an upper limb fracture or no fracture had less mobility problems than those who suffered a lower limb fracture who needed carer input for a longer period of time and maximum assistance until they were weight bearing as deemed by fracture clinic.

It can be seen from the case studies that all the hospital admissions were justified due to pain level, drug therapy needed, surgery and level of consciousness upon admission. All the patients and staff were in agreement with the decision as to whether they would be admitted or sent home. This evidence points to the accuracy of the referral criteria for ERS at home and the knowledge of the professionals involved in assessing each patient. The research also highlights the need for multi-disciplinary input and for professionals in Intermediate care to have an understanding of others roles (Nancarrow, 2004; Wade, 2004). This helps ensure that a holistic assessment has taken place and the patients' safety of coping at home upon discharge is determined.

Partnership working (NHS Plan, 2004) was evident in the need for the ERS social worker to refer promptly if the patient needed on-going care at home, but also that there were delayed discharges in the hospital group due to waiting for a care package to commence at home. This finding supports Baumann et al. (2007) findings in the literature review on delayed discharges. Therefore, this is an area for improvement to enable faster availability of social care packages to free up hospital beds when the patient is medically fit to be discharged.

The Early Response team is successful in delivering on the new health agenda in caring for people at home instead of them going into hospital (WAG, 2010). In this sample size five possible hospital admissions were prevented by the team's existence to extract suitable people from A & E. This type of work could have also prevented a readmission to hospital if a home patient was sent home without ERS' help and fell again. Thus, ERS are reducing the pressure on secondary care beds.

It is clear from the research findings that help with daily activities like washing, dressing, meals and toileting were important to participants and those were the activities that the injury had impacted on. This in turn affected their independence level and they become reliant on others for help and to rehabilitate. Therefore, an important requirement for patients to regain independence and achieve comfort was the assistance of care workers as supported by Loonan et al. (1991). This staff group is vitally important for Early Response team's work to be successful in keeping patients at home. Thus, when suggestions are made like more staff members are needed it is this group that should be a priority to expand. Subsequently more patients will be able to be helped at home if there are more carers. By the same token the participants who felt distress at having to wait a long time for assistance to go to the toilet may not have had to wait as long if there were more carers in hospital settings too.

The advantages of having care delivered at home as opposed hospital were that the patient was able to stay in their own home and less participants experienced loneliness in their own environment. Some participants had previous negative experiences of being in hospital and would have only stayed in if absolutely necessary. One participant felt that hospital was a place where people died, so they were pleased they could have care at home because of this belief. One staff member felt that being at home had led to a quicker recovery for the patient and another felt that if ERS had not helped the participant would have ended up in temporary residential care.

Medical problems were still identified when the patient receiving care resided at home. Therefore, it is important that the qualified nurse undertakes the initial assessment and has continued availability for any carer concerns as case manager for that patient. Also, having rapid access to the Intermediate care consultant's 'Hot Clinic' benefited this patient in that medications could be adjusted, investigations ordered and monitoring of blood pressure could be instigated. One disadvantage of having the care at home was that with one participant the ERS team found it difficult to extract their care as the patient had become reliant on the extra help. With therapy input to re-able as much as possible and the patient declining a care package the

ERS team was able to refer to volunteer services to step down the care received. Therefore, partnership working is necessary with organisations such as Age Concern who can provide up to six weeks input post-discharge free of charge for those with low level needs.

A disadvantage of hospital care mentioned was being moved not just between wards but hospitals for one participant. This was due to a bed crisis and when the participant had passed the acute phase of recovery another person needed that bed. The participant was sent for rehabilitation to another hospital, but even though they understood the bed crisis, this caused them distress. A solution to this would be to prepare patients upon admission that there is a possibility they will be moved as advocated by Molley et al. (2010). It will almost be impossible to re-arrange every ward so that there is a flow of patients from acute beds to rehab beds on the same ward, thus this is an inevitable event for some patients during their hospital stay. Obviously, having supportive staff that can recognise the psychological effects of a patient being moved into a new environment with new people, will prove beneficial for the patient's mental health.

Another patient was disappointed at the way they were discharged. No member of staff found them a wheelchair to enable their family to wheel them to where the car was parked and neither did they telephone a porter to assist them. This event could be an oversight by staff who were busy on the ward, but discharge procedures should be clarified on the ward. If a patient is deemed medically fit to go home, then there should be no risk with a porter transporting the patient to the relative's car at the exit. If there are problems getting into a car with a cast on then this should be anticipated beforehand by staff and an ambulance booked.

7.5 Conclusion

Results have been presented in this chapter from the data analysis of the case studies in relation to the research questions. This research study has occurred due to a new area of care emerging out of national policies (WAG, 2010) to tackle the strains experienced on the more traditional areas of care delivery namely primary and secondary care. Thus, it is interesting to look at the data for any reference on

how each care episode has impacted on the NHS care delivery as a whole. Senge (2006) believes we should not look at an isolated part, but in relation to its whole system as a change in one area impacts on another. From the evidence presented it can be seen that the knock-on-effect of successful care at home is saving a hospital admission. This bed is then available for an acute episode of care needed by a new patient. One can speculate that if this bed was not available then the new patient would spend longer on a trolley in the A & E department waiting for a bed.

Patient participants mentioned positive experiences of comfort (Kolcaba, 2010) in the four contexts whether their care was at home or hospital. They also mentioned their gratefulness for being able to be cared for at home which was a new experience for them. They were impressed that different types of professionals could visit them at home within such a short response time. Negative secondary care factors were identified such as being moved around several wards and not residing with other patients who were well enough to communicate with them. This can be interpreted as reference to the bed crisis most hospitals face where patients can frequently find themselves moved around wards to make room for the sicker individuals coming into hospital after them. Also, that the level of functioning of a typical hospital patient may include impairment of senses like not being able to communicate.

This is an important insight if intermediate care teams are pulling people out of hospital who are the fittest; the sicker patients are left in hospital. If a non-acute patient is discharged to have care delivered at home and the more acute or needy is left behind it is also prudent to ask what type of patient is then residing in our community hospitals. The author believes that further analysis on the knock-on-effect of the above regarding a whole system approach is needed.

There was a mismatch in the investigator's expectation of discovering commonalities in recovery rate times in each setting in this study. The results found that the exact time frame to recovery rates per injury/illness in the two different environments could not be ascertained. This was because patients were unique individuals regarding age, health status, whether they lived alone, any social support and level of comfort needs required. Therefore, this lack of generalisability regarding recovery rates is a

limitation to the study. However, it does support the paradigm of each participant being an individual experiencing their care pathway in their own lived context as a human being (Holloway and Wheeler, 2010). Summary statistical statements were still facilitated by the research, such as the unintended consequence of care delivery found of loneliness for six out of ten participants. This is important for other health care professionals to note and inform their practice in these two care settings.

CHAPTER 8

CONCLUSIONS & DISCUSSION

8. CONCLUSIONS & DISCUSSION

8.1 Introduction

In conclusion, this research study has examined how a locality is performing against the policy drivers and NHS demand pressures to provide an alternative type of care system at home. The alternative type of care at home was compared to hospital care through patient and staff experiences gained from qualitative interviews. In chapter one, background information was given to enable the reader to put the research in its current context. The history of the NHS and policy literature was presented to depict how intermediate care came into being. A concept analysis was performed on the area of intermediate care to provide the reader with greater understanding of this care area. A detailed account of the Early Response team's work was presented to educate the reader on this service area within intermediate care. A literature review was performed to ascertain research on this subject and to show the need for this research to take place encompassing the patients' and staff members' perspectives.

Next the research design, methodology, data analysis and results with accompanying discussions took place. This has led to the recommendations for practice which will be presented in this chapter. It is concluded that even though primary and secondary care are necessary service providers that intermediate care can help both service areas save money and resources as evidenced by McCain (2012). Therefore, an investment in intermediate care can help save costs to the NHS in the long run. However, the long term impact on the whole system of NHS care delivery in light of future demographic changes and limited resources are not known yet. Senge (2006) explains that the interrelated components of a system often take years to play out their effects on each other.

This research has utilised the case study method as described by Yin (1994) to describe the real-life context in which an intervention occurred, described the intervention itself and explored situations where the intervention being evaluating has no clear set of outcomes. Obtaining data from the lived experiences of participants on two different care pathways has helped construct the answers to the research questions. The results of the multiple case study analysis show us that

ERS (Early Response Service) are providing a successful service at home for patients who may have previously taken up a hospital bed, so this has answered the main research question.

ERS referrers and staff are identifying the correct type of patients who can be cared for at home as evidenced by the agreement between patients and professionals as to whether a hospital admission was necessary. A new finding that emerged from case study data analysis was that one area of improvement could be facilitating hospital discharge. Due to the delays in obtaining a social services care package there is an opportunity for ERS staff to not only pull suitable patients out of A & E, but out of the hospital wards when deemed medically stable. ERS has occasionally done exactly this, but staff resources restrict the amount of people their carers can look after in their own homes until their social services care package starts. Parkin (2009) states that health economics concerns working with an increasing demand of patient health needs with scarcity of resources such as personnel, equipment and buildings.

8.2 Conclusions about the Research Questions

In light of health policy plans to shift more acute care to the community (WAG, 2010) this research study proves that the Early Response Service has successfully achieved an alternative type of care available to patients in that they can be treated in their homes instead of hospital. Allsop (1995) says the success of policies may only be determined by measuring their outcome. The qualitative interviews gave the patients the opportunity to talk about their lived care experiences which have been presented in chapters five and six. On the whole all patients who received care at home or hospital were satisfied with their care and were assisted to achieve comfort in the four contexts. However, not all patients had positive experiences along their care pathway journeys where some cited incidences of pain, cold and hunger at A & E, and the unintended consequence of loneliness. Having needs met under the four themes of physical, psychological, social and environmental produced comfort in the form of relief and ease (Kolcaba, 2010) and satisfaction with their care.

Staff were given the opportunity to talk about their assessment of each patient, the factors involved in their recovery, barriers to care and why a particular pathway suited that patient's needs. They were also able to identify any service issues or suggest improvements like ERS being available to all wards, having a 24 hour service, more staff and being able to pull patients out of hospital as well as preventing hospital admissions.

It was seen that the criteria used by the Early Response Service was accurate in enabling identifying the correct type of patient who could be cared for at home. Kast and Rosenzweig (1985) state that organisational goals may be stated in general terms, but it is up to the organisational participants to modify the pattern and fill in the details. All admissions and discharges to home care were deemed appropriate by patients and staff. Therefore, the only changes that would be needed would be linked to any expansion in the service that the Early Response team can provide. The factors that determined whether the patients had to remain in hospital were found to be linked to the severity of injury, needing strong analgesia and surgery.

An example of a change to the referral criteria would be the ability of being able to give intravenous antibiotics in the community, so patients such as those with cellulitis of the leg could be treated at home instead of at hospital. This has cost implications in employing more nursing staff to facilitate morning and evening dose administration, a doctor or GP who will take responsibility for monitoring the treatment effects and staff training with regards cannulation and intravenous medication administration. This cost would have to be balanced against the cost of this client group staying in hospital to receive their medication. With regard to inequalities in health if one locality achieved this it would be advocated that it became available to other localities as well. Care options for the patient should not depend on where you live as stated in many NHS and WAG policies the aim is to reduce postcode lotteries ('A Postcode Lottery on Care', DH, 2007; 'NSF for Coronary Heart Disease', DH, 2000a).

Recovery times and self-care abilities were very individual to each patient. Some patients had complications such as urinary retention or needed a second operation.

These complications were unforeseen so one cannot generalise that a patient with a particular injury will have the same physical, psychological, social and environment effects as another with the exact same injury. Thus, it is down to the severity of injury and its consequences to the individual which determine their recovery rate. That is not to say that interventions such as assisting with meals and hygiene needs did not help each patient, because it did, but one cannot generalise a time frame for all patients.

Advantages and disadvantages of each pathway have been found. The home patients were appreciative of being able to stay in their own environment and be cared for. Medical problems were still picked up such as low blood pressure as the patients were monitored by the nurse assessors and had access to the Intermediate care consultant if necessary. Staff felt they were able to transfer care easily to voluntary agencies such as Age Concern in a step down approach, but sometimes found it difficult to extract their service. Both patients and staff were impressed by the rapid response of the multi-disciplinary team in the community to visit them at home.

A disadvantage mentioned by home patients was in not being visited by the same carer all the time and on rare occasions there was a breakdown in communication with the times the carer would call. The majority of patients found the free help at home so useful that they would have liked it to go for longer. The hospital patients mentioned disadvantages of delayed discharges, having to move wards and waiting times for toileting. Advantages were being able to receive maximum assistance, accessibility of doctors and some liked the food.

Both sets of patients mentioned loneliness as a factor in their care experience which was not anticipated. It was also surprising that this occurred more frequently in hospital with other patients and staff around in a busy environment. Thus, even though the patient at home may live alone it was the familiarity of the environment and their established social networks which could have resulted in less loneliness experienced. Also, their relatives could visit freely instead of being restricted to visiting times or when the ward was closed due to infection.

8.3 Conclusions about the Research Problem

The research problem pertains to the newer initiatives to invest in care at home under the umbrella of intermediate care due to high demands on other care sectors such as primary and secondary care. With the availability of more care at home then hospital beds are saved and utilised more appropriately for those who need them. It also helps primary care by grouping together community professionals and providing them with an alternative type of care to refer to rather than admit to hospital.

The significance of the research strategy in meeting the study aims were that it was not needed to merely reproduce number of bed days saved, but to delve deeper into the real life experiences of journeys of healthcare to discover what the patient and staff experiences were to truly uncover how successful care was and what comfort or discomfort occurred along their pathways. This data helped unfold advantages and disadvantages of the two care pathways and what determinants occurred which made them follow a particular path. Thus, rich data was needed in the form of the case study approach and semi-structured interviews. It achieved the aim of exploring the complexity in the phenomenon of intermediate care in order to answer the research questions. By utilising a multiple case study approach avoids bias of one case and if one extreme opinion was expressed it could be put into context of other opinions from the same group of hospital or home patients.

Gangeness and Yurkovich (2006) argue that case study design fits well into the meta-paradigm of nursing consisting of person, environment, health and nursing. Therefore, the components of the methodological approach match the conceptual design and theoretical underpinning of this nursing research study of remaining holistic nature. To have too narrow a focus may have left out aspects of the research problem which needed answering. However, Yin (2003) advised having a case study protocol like a mental framework to maintain the line of enquiry and theoretical propositions at the start to ensure the research contributes to the particular field of knowledge being studied. The researcher set out their theoretical propositions and study protocol in chapters three and five as a framework to answer the research problem of receiving care at home as opposed hospital.

To draw conclusions about the research problem it is useful to re-look at the available evidence on intermediate care in the literature review in relation to the research results.

8.3.1 Type of Professionals

Loonan et al. (1991) had found that patients treated at home did not solely require nursing care which is more expensive than carers. ERS employs nurses to undertake initial assessment and medication reviews. The nurses then set up a care plan for the carers to undertake such as monitoring blood pressure and providing assistance with washing and dressing. This frees up the nurse to undertake more assessments and look after those with a greater acute medical need. Therefore, the suggestions of increasing staff capacity in the research would have to take into account increasing carer capacity, as well as nursing and therapists. They are cheaper and the ones who deliver the care on a daily basis at the patients' homes.

Bowles et al. (2002) discovered unmet discharge needs of patients who then became at risk of readmission to hospital. This highlights the importance of multi-disciplinary discharge planning. Both the ERS team and ERS referrers were teams made up of therapists as well as nurses so a multi-professional view could be taken. A patient may be medically fit, but may have problems mobilising which could cause a readmission if a fall occurred at home. Thus, the professionals involved in this research are experienced enough to make clinical decisions and have an awareness of each others' roles when assessing the patient. Senge (2006) states the intelligence of a team exceeds the intelligence of individuals in a team.

8.3.2 Doctors' Input

ERS did not take referrals from GPs at the time of the research, but were making inroads via the intermediate care Consultant for this to come to fruition. Davies (2009) produced a case study which proved that a Consultant home visit prevented an unnecessary hospital admission. The partnership working between the GP and expert advice of the Consultant with the resources of intermediate care at their disposal kept this patient at home. Therefore, having an intermediate care consultant provided a useful resource for GPs. In the research locality GPs would refer to the

'Hot Clinic' anyone they thought were at risk of admission so the Consultant could perform an assessment and prompt investigations to intervene if it was possible to stay at home. This is a beneficial service to community, but there is also room to expand this service and open it up to more GPs as well as ERS taking on more GP referrals.

Regen et al. (2008) believes the way forward for intermediate care is to engage the medical profession by involving more doctors in the service. However, Wade (2004) says its success is dependent on team working, professional decision-making and advocates care pathways so the patient journey can be clarified. It has been part of this research's aims to explore patients' journeys and even though there is a smooth transition of care to the Early Response team a generalised care pathway is not advocated. This is because care is based on individual needs, can change daily and length of time ERS is involved with a patient varies according to individual patients' needs. Rather, it is advocated that there is a raising of awareness of intermediate care and the work that ERS does. The criterion used by the Early Response Service clarifies their remit of care provision.

8.3.3 Partnership Working

Thomas & Lambert (2008) researched the perceptions of staff referring to intermediate care. They identified themes of shared responsibility, recognition of conflict areas and co-ordinating services. This research would support these findings. The co-ordinating of services was imperative to get a patient home from A & E in a safe and timely manner with all equipment and professionals in place. There is shared responsibility for such co-ordination between the referrer and the ERS staff member who manages that case. Recognition of conflict areas could be frustration felt at having limited resources. On occasion the referrer may have a slight delay in getting the patient home if ERS had no capacity at that time.

Qualitative interviews that took place by Baumann et al (2002) found three themes emerge that caused a delayed discharge. They are health and social care capacity issues, internal hospital inefficiencies and inter-agency issues. Also, that these were caused by poor communication within the multi-disciplinary team and complex

access to intermediate care. In relation to this research the theme that holds relevancy is the health and social care capacity issues mentioned by both patients and staff in the research interviews. No internal hospital inefficiencies or inter-agency issues were raised with regard facilitating a discharge.

Baumann et al. (2002) discuss solutions for their findings that a designated discharge team is in place and that patients are explained to that when their acute phase of illness is over they have to go home, but do have the choice of what discharge care services they receive. In this research no patient expressed a desire to stay in hospital longer than what was decided upon by professionals. It also appeared that before staff gave the option of Intermediate care at home that the patients did not know the team existed. Thus, in relation to this research evidence, the need to raise awareness of intermediate care amongst staff and patients has to occur.

There were no problems mentioned between the multi-disciplinary team regarding communication. One can speculate that this has been helped by the fact the those working in intermediate care in the research setting and their referrers have been working for several years in multi-disciplinary teams so are used to communicating amongst different professions in order to deliver effective patient care. One can also speculate that ERS having a four hour response time promotes swift information gathering and effective communication amongst professionals. Blackman (2006) feels partnership working is helped by sharing priorities.

8.3.4 Transitional Care

It has been proposed that an area which ERS can improve on and expand into is that of facilitating hospital discharge. Crotty et al. (2005) in a randomised control trial found that transitional care beds provided a useful care alternative to staying in hospital waiting for a long term placement. Such beds can exist in Residential or Nursing Homes and can remove the stigma of being a 'bed blocker'. No patient in this research study expressed a strong feeling about being a 'bed blocker' but three were waiting for a social care package to be put in place before they could go home.

ERS did try and accommodate these hospital patients in bringing them home whilst waiting for social care.

In the research locality it has been mentioned the possibility of linking in with the council to designate Residential beds for Intermediate care's use, so this is another avenue open for future admission avoidance or facilitation of discharge. Especially for those that need 24 hour support, which ERS cannot provide with their present level of resources. Fleming et al. (2004) also support the use of Care Home beds for rehabilitation of patients and found there were no major effects on the well-being or activities of the patient being moved from hospital care to social services care.

8.3.5 Health Outcomes

Kaambwa et al. (2008) presented important findings from five case study sites on the costs and health outcomes of intermediate care. They found that the work of intermediate care was almost an equal split between admission avoidance and facilitation of discharge work. Therefore, the Early Response Service has commenced by linking with A & E to prevent unnecessary admissions and is moving towards taking on more facilitation of discharge work, so it will be interesting to examine the percentage of split between the two service aims. It is a recommendation for practice that more discharges are facilitated to free up hospital beds, but obviously ERS has to work within its capacity, whilst preventing admissions also.

Kaambwa et al. (2008) found that some patients were inappropriately admitted to intermediate care. In relation to this research study it was not the case that any patient who came home to the care of ERS did not require it. Rather that two patients after three-five days of carer input felt they could now manage without the assistance to wash, dress or prepare meals. One of those patients still needed the carer to make the bed and empty the commode as they could not get upstairs. Thus, an individualised care perspective comes into being in that patients recover at different rates with different pain levels and different needs to help them back to independence or attainment of comfort. This research study specifically looked at the

Early Response Service and not the whole of the Intermediate care team's work, so it is quite possible that there are inappropriate referrals into the service.

8.3.6 Professional Satisfaction

Staff members were not directly asked in this study about their level of job satisfaction. Nancarrow (2007) found that staff working in intermediate care had a high level of job satisfaction because they were working in an enabling philosophy care environment. They had increased autonomy and worked in multi-disciplinary teams. Nancarrow (2007) found that working in intermediate care was seen by some as deskilling the professional and advocates that more hospital and community staff are rotated to intermediate care to better understand its work. No professional expressed a concern regarding deskilling and it was quite obvious the multi-disciplinary knowledge and links they held helped their decision-making in practice.

Nancarrow (2004) explains that there is role overlap of professionals in intermediate care as holistic assessments take place and the professional has to decide which team members' input is needed by the patient. Nancarrow (2004) argues such professional role overlap enhances patient care and optimises limited staff resources. The results of this research study suggested that there was rapid provision of equipment and effective multi-professional communication to meet the patients' needs at home and in hospital.

Dahlgren et al. (2004) states a paradoxical situation exists where the knowledge base legitimises the claim to being a profession, but yet professionals are striving to become more patient-centred using a single-case approach. They have incorporated modern demands for quality and patient safety by individualising care and are successfully maintaining a knowledge base, for example, knowledge on a particular disease but two patients suffering that disease may experience different symptoms, so care is tailored to suit both. Dahlgren et al. (2004) calls this clinical reasoning, which can be learnt by reflecting on practice experiences and knowledge base. Titchen (2000) suggests expert practitioners transform theory in a variety of ways to make it useful to particular patients in certain situations. This is new knowledge

gained in the form of practical principles. Thus, those professionals working within intermediate care are expert in their specialist field of care delivery.

8.3.7 Future of Intermediate Care

The patient sample in this research is similar to that of Brooks' (2002) research on a rapid assessment service where the most common reasons for referral were falls and assistance was needed with activities of living. Brooks (2002) found that there was an issue with engaging the wider health and social care community and the long term impact of intermediate care on health and social care services are not known. It was mentioned in the concept analysis, chapter two, what the future of intermediate care may look like and this middle area of care is used to working in a changing environment to deliver their care to where it is most needed. Therefore, how intermediate care and the Early Response Service functions in the present may be very different to how it functions in ten or twenty years from now. Therefore, the long term impact on whole system of NHS care delivery is not known at present.

No participant mentioned the desire for assistive technology or whether they thought it would help facilitate a discharge or provide increased safety at home. However, it was found out that the social worker's assessment included ascertaining if devices were needed like an emergency pendant alarm and key safe. The occupational therapist in their assessment could recommend apparatus such as falls alarms and bed sensors. Therefore, the evidence in the literature review by Dewsburys (2012) can help inform on the shape of how intermediate care may be delivered in the future via not only telecare, but telehealth also.

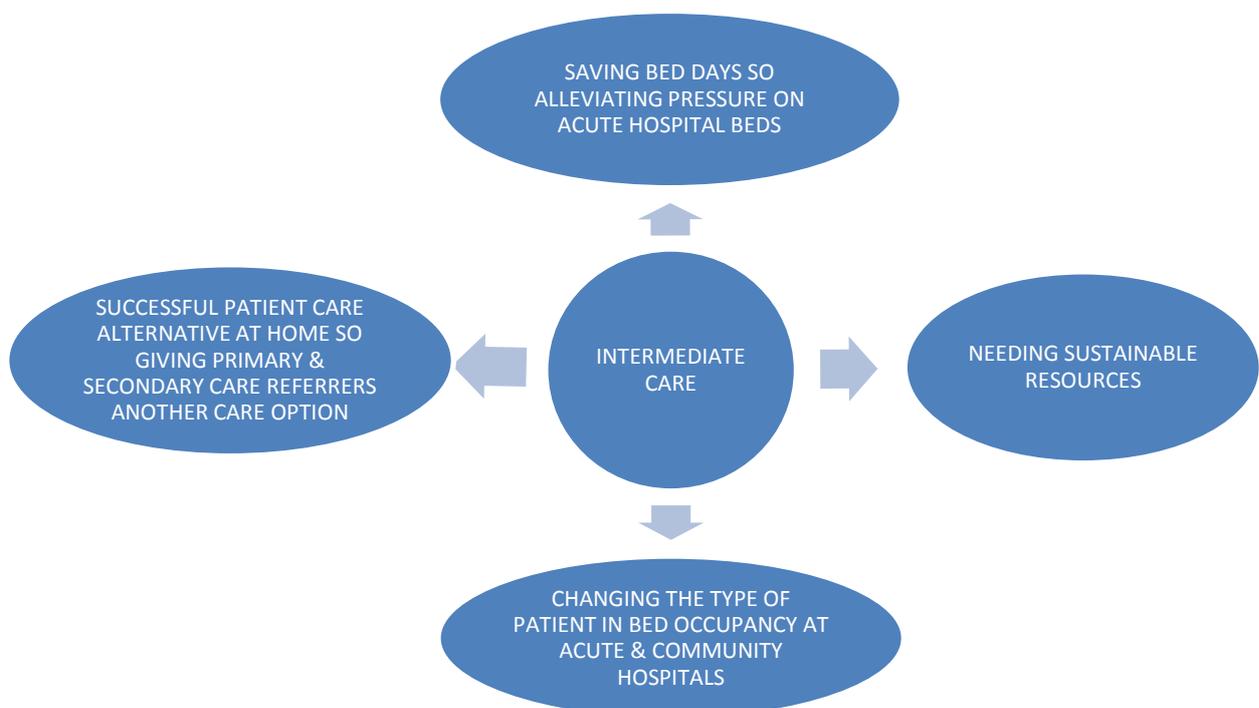
8.4 Implications for Practice

In summary it is a positive knock-on-effect the Early Response Service is having by saving a hospital bed which can go to someone else needier. The negative effect is dealing with increasing demand due to the projected demographic changes with limited resources and budget (DH, 2002). Also, the type of patient left behind in hospital is changing as a consequence of home care initiatives. For example, one can speculate a nurse who worked in a community rehabilitation hospital with middle

aged patients may now find their ward has changed to a long term elderly care ward with patients who require complex discharge planning. The reason for this is that the fitter patients are now having shorter length of stays and are being cared for by a multi-disciplinary team in the community. However, it does help sharpen the boundaries of secondary care of dealing with acute care. This will be the future challenge of the NHS system with a growing population of elderly people living longer with chronic illness and complex needs (DH, 2002).

It is interesting to summarise the effects of intermediate care on NHS service delivery. This is presented in a diagram below.

DIAGRAM 4 – SUMMARY OF EFFECTS OF INTERMEDIATE CARE



With reference to the Early Response team the continuity of the same carer was mentioned as well as the length of service as weaknesses. Thus, again the need for more staff was indicated and more money suggested increasing capacity and resources in order to provide longer care. If there was no more money or resources available then the service can only be offered to a small population with a quick turnover to allow for more patients to benefit from it. If money was taken from

elsewhere in health budget to pay for more staff at home or hospital then what service is it taken from? Hunter (2003) explains that with pressure to show immediate results health policy can focus on the visible health care delivery outcomes like number of bed days saved, rather than going upstream and focusing on longer term health outcomes such as health promotion.

There are obvious financial implications in employing more staff whether it is in the community or in hospitals. If care is prioritised then those areas with patients with an acute need will be allocated any additional money first. However, if ERS has a separate funding stream then it is possible to make a case for additional resources as proven by the success of their work. If ERS was to expand more into the area of facilitating discharge then perhaps social services could fund additional carers. There did not appear to be any funding problems regarding provision of equipment for the participants. Some participants returned equipment when they no longer needed them so it could be allocated to someone else.

A recommendation for practice is for social services to have a pooled budget with health regarding intermediate care and initiatives such as the Early Response Service. A dedicated funding stream can help social services meet targets of facilitating hospital discharges when there is a delay in setting up packages of care. This has happened in this locality where social services have allocated funds to employ more health care support workers to help with prevention of admissions and facilitation of discharge. The reason for this is that the Early Response team can look after these patients in the community instead of hospital whilst a care package is waited for. Thus, this 'pull' effect is very important in saving on hospital bed days and preventing delayed transfer of care.

One patient participant said they would like care in this country to be on a par with that in Canada, so they have experienced in their opinion a better system of care than the NHS. Staff participants make references to the NHS system as a whole. Comments were derived from the data such as hospital staff saying they need more staff to be able to give the care they want to give. Also, they felt that the delay in care packages being set up meant a longer stay for patients in hospital when they were

deemed medically stable. This points to the system as a whole needing to work in tandem. Without social services co-operation in underpinning health care then proper utilisation of the health care delivery systems cannot take place. Care packages are needed to help discharge patients. Social workers are needed to assess if home is an option for the patient as opposed a care facility. Also, for financial advice on benefits as one participant said they cannot afford to pay for care at home.

8.4.1 Participants' Recommendations for Practice

From the results of this study and the participants' positive and negative comments 13 recommendations for practice have been formulated below.

1. For the Early Response team to have longer input with clients and to increase the number of health care support workers. This could mean extending beyond the ten days to up to six weeks input. This will enable fewer patients to be passed onto social services if they only need a temporary care package until they have reached independence again. For actual care delivery the staff group of health care support workers are vital. Therefore, in order to widen the availability of the service it is recommended that more are employed. This has a financial impact, but the Early Response team cannot achieve a bigger impact on saving hospital admissions and facilitating discharge without increasing numbers of these workers.
2. Help to pay for social services care packages when the Early Response team withdraws their care. One patient could not afford £10 towards the cost of continued help from social services. Voluntary agencies are very important in picking up care in a step down fashion where the acute needs have been resolved and the patient requires minimal help and support. One staff member explained that the team had difficulty in extracting care. They deemed the patient was now back to their former level of independence, but the patient did not want the visits to stop. This was probably due to anxiety of now having to cope alone again. It is recommended that upon entering the team's service

patients are asked to sign a form to state that they understand the length of the time that input can continue for and that efforts will be made for alternative services if deemed needed post-input. To save costs it may be worth therapists such as occupational therapists targeting these people to help address their anxieties and to build up to their confidence in daily functioning. Also, to refer to voluntary services that can not only help with shopping and cleaning, but have a befriending service as well. For the professional it is important when care is withdrawn that the patient is deemed safe at home.

3. To have the same or as few as possible carers visiting the patient. One patient found it difficult to build up relationships with the carers as they had so many different ones visit them. The Early Response Service does attempt to give continuity of carers for patients and often arranges patient visits close to where the carer lives to ensure timely response. However, there may occasions where two or more different carers visit the patient during the course of their input. The recommendation is that this is kept to a minimum to allow therapeutic relationships to develop. With one patient, carers had called on two or more occasions to find the house empty. It is recommended the patient understands to be at home when the carer comes to visit them. This can be achieved by a patient-carer contract at the start to explain the aims of the services and that their co-operation is necessary.
4. Faster transition from hospital care to social services in the community. It has already been discussed the impact of when a patient is deemed medically fit, the delays experienced in waiting for a care package. It is recommended that more resources are made available to the Early Response Service so they are able to pull patients out of hospital who are waiting for care packages to start. Some work in this area is already taking place and will free up hospital beds, but without more resources the impact will be limited.
5. A higher visible presence of the Early Response Service on all wards and not just A & E. To have every ward in a hospital as well as community

referrers such as GPs referring to the service would open the floodgates to the Early Response Service. Therefore, if no further resources can be allocated to increase staff numbers, then research must take place that this intermediate care service is targeting those in most need. It is recommended that the intermediate care manager liaise with those managers in primary and secondary care to target areas where there is the most need. This achieves equity, but not equality to all in accessing the service. Therefore, more work is needed in raising the profile of the Early Response Service in primary and secondary care, but this service would need more resources in order to take on more patients. It makes sense to intervene in the community before the patient reaches the stage where they need hospital care. Some work is already underway to accept GP referrals and GPs have access to refer into the intermediate care Consultant's 'Hot clinic' to assess those who are at risk of admission. Therefore, it is recommended that this work continues and the availability of more carers would ensure timely access to the service to be looked after at home instead of admitting to hospital.

6. To increase staffing numbers on the wards. Several patients identified how busy the staff members were which impacted on one patient's need for toileting. Nurses had to prioritise their time to those most needy and often a patient would have a long wait for assistance to go to the toilet. Elimination is a basic need and can create anxiety, incontinence and constipation if there is a delay (Women's Health, 2011). Therefore, more effort must be made to meet the basic needs of patients in hospital to ensure their comfort. Another comfort need in hospital was having a choice of food where one participant liked the food, but another found it distasteful. The only solution for this is that a wider choice of meals is offered and if it is a particular problem for one patient then they are asked to make a list of what foods they like so the kitchen can try and accommodate their needs.
7. To have assistance upon discharge to get into a vehicle that is transporting them home. One patient's whole hospital experience was spoilt by the fact

they had problems getting to and in a relative's vehicle upon discharge. In this case it may have been more beneficial for the patient to go home via ambulance as they had a cast on their leg. A failsafe would be that a porter is called to take the person in a wheelchair to their relative's car or that the nurse goes with the patient to the exit to ensure their safe departure. This would have implications of a nurse being absent from the ward for any length of time. Therefore, it is recommended that all patients are assessed upon the decision to send home that they are suitable to travel in their transport or not.

8. To have less complications post-surgery. Unfortunately one patient had complications in that the fracture would not knit together properly so had to undergo several operations. One can speculate that this was not foreseen to happen and the surgeon had aimed for the first operation to work. Therefore, it is recommended to give psychological support to patients in this position and ensure effective communication about what is happening so anxiety is kept to a minimum. Psychological support was also needed to overcome barriers of patients who had poor prior experience of NHS care. Some patients said they would not have stayed in hospital unless absolutely necessary due to their prior bad experiences of care. Two patients had either lost a relative through infection or had serious health complications of contracting an infection themselves. Therefore, it is recommended that the work to reduce the risk of cross infection continues. It may be beneficial for Infection Control nurses to speak to these individuals to explain the measures that are in place to reduce infection and to give statistics of the realistic chance of gaining a hospital-acquired infection. Patients must be reassured that it is not the intent of staff to cause them harm, but to help them. It has proved beneficial for these patients to have their care delivered at home.
9. Loneliness was an emotion experienced more by hospital patients than those at home. This was exacerbated by the lack of visitors due to the norovirus. Also, being in unfamiliar surroundings compared to being at

home where patients had established social networks impacted on the patients. Several patients mentioned they had difficulty in trying to talk to other patients as they were either too ill or incapable. One could recommend that patients with the ability to converse are put together in a ward, but realistically this would be impossible due to the turnover of bed occupancy. Also, if a nurse educated a patient how to communicate with a deaf, blind or dysphasic patient then that would breach their right to privacy. It is not advocated that a person be employed on a ward just to maintain social activities of patients due to costs. However, staff can encourage use of the radio, television, or bring patients who want to converse together in a dayroom.

10. To have residential beds available to the Early Response Service. This work was underway in collaboration with the local council. Intermediate care's nurses and therapists can provide input into a Residential home for someone who is not ill enough to go to hospital, but is not safe enough to be left in their own home over a 24 hour period. This stops a hospital admission and ensures the patient's safety being in Residential care. This can be deemed as a rehabilitative stage to bring the patient back to independent living. If this is not achieved then the patient is in a safe environment whilst the multi-disciplinary team help the patient decide their future care needs. Also this bed could be used as step down care from the hospital. This again has financial implications for staff to provide input to these occupied beds.
11. To return all equipment loaned. It is common for a patient in the community who is using a wheeled zimmer frame to have one upstairs and one downstairs. One patient also had an outdoor walking frame and when her mobility had improved she returned one of the frames. In the present economic climate and if the Early Response Service widens its availability to patients then prompt return of equipment to stores is essential so that it can be cleaned and loaned to someone else.

12. For a formal induction of staff to intermediate care. Some staff working in the community and hospitals are unaware that the Early Response Service exists. Therefore, work must be done in order to raise the profile of this team as an alternative type of available care. Also, there may lack of understanding of the different roles within intermediate care or an assumption of deskilling (Nancarrow, 2007). Therefore, in having a formal induction programme and staff input into competencies needed to work in such an area can only serve to bring more value and notoriety to their roles. This middle area of care has shown that knowledge of the multi-disciplinary team's roles is essential (Nancarrow, 2004). In a holistic assessment staff are identifying needs that can be met by other professionals in their team as well as by themselves. This ability to holistically assess comes from learning and shadowing other members of the team and is a distinct quality of intermediate care.

13. For the NHS to be like it is abroad is one patient's recommendation. The NHS is unique in that care is free and available to all. Although people pay their national insurance contributions through their wages to help fund it. Private health care may ensure quicker access to see a consultant or to have an operation. It is in the patients' best interests that good practice is shared and perhaps the UK can learn from other health systems abroad.

It is important to find out what specifically this patient thought was better and to compare the alternative care pathway in this country. If it was the modern buildings and environment then work is underway to build new hospitals in this country (NHS Wales, 2006). If it was the food then suggestions can be made the local hospital. This patient has a choice if they wanted quicker access to have an operation of paying privately or to wait on the NHS. If the wait was thought detrimental to their health then the patient's GP would deem their need as urgent and they would have their operation quicker.

This patient did previously contract an infection from hospital, so would need reassurance on the infection prevention measures in place when they need to go to

hospital. They also brought politics into the discussion as to why the NHS exists. Even if politicians use the NHS as a vote seller in elections it still exists to provide a health service to the UK population. It remains to be seen in this present economic climate what the future NHS will look like, because to make improvements or employ more staff as the participants' recommendations suggests costs money which is not available at present.

8.5 Implications for Policy

This next section will discuss the research implications for policy such as partnership working and objectives to shift more care to the community (WAG, 2010). The NHS Plan (DH, 2000c) advocated health and social services working in partnership to promote the independence of older people. Also, 'The National Service Framework for Older People' (DH, 2001) in the intermediate care standards section stated integrated services must exist to promote faster recovery from illness, prevent unnecessary hospital admissions, to maximise independent living and support timely discharge. Therefore, the beginnings of the partnership working between health and social services have occurred, but there is room for improvement in freeing up hospital beds by prompt delivery of social care. The social worker on the ERS team would assess and prioritise patients for care packages so capacity was freed up to take on new patients.

It can be seen that ERS is intervening for the right person, at right place and at the right time as stipulated in several policies concerning the shift in care delivery such as 'Changing for the Better' (First Local Health Board, 2010) and 'Better Health Services' (First Local Health Board & Anytown NHS Trust, 2006). They are providing a community alternative to hospital. It is possible in the future that even though in the research sample none of the hospital admission patients could have come home, that if ERS provides a 24 hour service and embrace more acute nursing that the scope of type of patients will be widened who can be cared for at home. For example, a patient who needs intravenous antibiotics as well as assistance with daily living activities.

This study has focused on how a locality is performing against the aims of recent policy literature from the Welsh Assembly Government and Central Government as discussed in chapter one. The interpretation of these in intermediate care has been decided locally dependent on population needs and available resources. However, even though there is a benefit to interpreting policies locally in relation to population needs, there should also be an all Wales approach to intermediate care and community teams who can help alleviate pressure on secondary care.

Therefore, it is advocated that localities such as the research area have network links with other Welsh localities so that initiatives and gold standard practices can be shared. For example, at the time of this research, the locality was in its infancy in accepting GP referrals. They were networking to make available their service to a group of GP practices. Other localities only take referrals from GPs and not from A & E. Therefore, such localities can learn from each other how they incorporate both secondary and primary care referrers with the limited resources they possess. Therefore, a recommendation for practice is that an all Wales approach to intermediate care is devised incorporating flexibility to local population needs.

Policies such as 'Newtown Clinical Futures' (NHS Wales, 2006) and 'Designed For Life' (WAG, 2005) advocate cutting the length of stay of hospital admissions. For the health and social care professional this objective must be carried out in partnership ensuring the patients' safety at home and provision of home services if needed. The 'Wanless Report' (DH, 2002) stated that there should be seamless care delivered by partnership working. ERS' work with A & E at the research site appears to be achieving this type of continuity of care for the patient. Also, the research results suggest there is not only a transition of care from A & E to ERS, but from ERS to voluntary agencies such as Age Concern/ Age UK. Therefore, it can be inferred that this is a step down approach in care needed from hospital to independent living at home.

The 'Wanless Report' (DH, 2002) called for a shift in the thinking of how care is delivered. In referring back to the chapter two on concept analysis of intermediate care being a middle area of care, it is evident that this shift concerns efforts made in

this middle area of care. This is where unnecessary hospital admissions can be prevented and early rehabilitation intervention can take place to maintain independence and comfort at home.

Before ERS existed it can be speculated that the five patients who went home may have ended up in hospital which is not what any of them wanted. If they had gone home without nurse, carer, equipment and therapy input, they may have fallen again and been readmitted, especially those that needed to live downstairs whilst undergoing physiotherapy to achieve the goal of climbing the stairs. Thus, in this research sample hospital bed days have been saved. Therefore, the money has been saved if community care is cheaper than care in a hospital bed (McCain, 2012).

Other policy implications include a need to do more to prevent loneliness in old age and assistance to help them engage with society. Maintenance of independence should be promoted whether this is rehabilitative in improving mobility or maintaining the ability to drive a car as it has positive physical, social and psychological effects. Access to good public transport to get to the shops will also help maintain independence of older people. The promotion of charities such as Age UK (2013) is very important for older people as they can receive free help and advice concerning care needs, finances and social support.

8.6 Validity and Limitations to the Study

Baxter and Jack (2008) said in order to achieve validity or credibility of case study research the investigator has a responsibility to ensure the research question or propositions are presented and case study design substantiated. Also that the sample population is appropriate, data are collected and managed systematically and the data are analysed correctly. This study has achieved this; however it has not triangulated data methods but rather triangulated data sources of three types of cases to help increase reliability of results. Baxter and Jack (2008) state a multiple perspective allows for comparison of data, idea convergence and confirmation of findings to increase the quality of the study.

Kohlbacher (2006) supports this saying triangulating data sources helps validity and that qualitative data presents such rich detailed data which can support any conclusions reached. There were three sources of a data in this multiple case study of the home patient, the hospital patient and the staff members who assessed them. Each of these sources was an individual case study making up a unit of measurement of four cases to enable comparing and contrasting of data. Therefore, this research has not used one source as a case study, but multiple opinions of participants in order to reach conclusions about the research questions. This increases its reliability and validity.

Kohlbacher (2006) went further to explain case study validity involving addressing objectivity issues, construct validity, internal validity, reliability and generalisability. Objectivity issues or internal reliability was discussed in the ethics section regarding the insider perspective in chapter four. This was addressed where the investigator no longer works in this field, attended research workshops, sought advice from the academic supervisor and had a heightened awareness of probing any common language statements made in interviews. Therefore, effort was made to make the study as reliable as it possibly could be and the investigator's philosophical stance made transparent.

The researcher would argue that having insider knowledge facilitates more depth and understanding for themes to be explored. A researcher with no familiarity of the health service may miss important clues or topical subjects within this area of practice. They may have an advantage of being objective from the start, but may not interpret what data means for the nursing profession or patient care. Delamont and Atkinson (1995) make several recommendations on how to make the familiar strange including treating the regularities of everyday life problematic. In other words, to be transparent about shared knowledge with participants and to make problematic anything familiar.

The researcher believes by presenting qualitative extracts and making clear how key words were derived from data along with applying a theoretical underpinning helped make the familiar strange. By utilising a framework of searching for physical,

psychological, social and environmental factors, age discrimination and loneliness, and finally examining comfort or discomfort gave the study an objectivity that the researcher would not have had previously. Thus, efforts have been made to strengthen the internal reliability of the study, even though the researcher previously worked the service, they had no knowledge on how or what research strategy would be applied to that service.

Construct validity is whether the evidence correctly corresponds to the theoretical propositions (Kohlbacher, 2006). In this study the qualitative data gained from the participants has been accurately interpreted by the investigator. This was helped by presenting qualitative extracts in the results and showing transparency in how particular concepts or conclusions have been reached from the data.

The investigator has also made explicit any speculations or interpretations from the case study data results. For example, from the data findings it was interpreted the need has arisen for a 'pull' effect from hospital whilst waiting for a care package as well as preventing inappropriate admissions in the first place. Also, with one participant saying her body could do it anymore was interpreted as a sign of aging and was categorised under the physical analysis theme. Kohlbacher (2006) explained that internal validity concerns the postulated relationships between concepts.

Yin (1994) talked of rival explanations and the investigator must be transparent about data which may emerge which is in contrast to propositions held. This notion of a rival explanation was included in the study for an alternative explanation for the high percentage of loneliness found in the patient sample. Norovirus impacted on hospital visiting which could have increased patient loneliness rather than loneliness being a result of old age or different environment.

Bryman (2008) explains that in qualitative research external reliability of study replication is a difficult criterion to meet. Kohlbacher (2006) agrees and says that there is a problem in trying to replicate studies as the researchers will be different and may generate different findings. Kohlbacher (2006) believes that reliability

should be addressed by presenting with transparency the investigator's propositions, methods, data generation and its interpretation, so that the public can have faith its findings. This study has achieved this in being transparent about its paradigm, methods and findings.

It was discussed that Linertova et al. (2011) found case studies on intermediate care were difficult to compare in a systematic review. Therefore, grouping this study with others may be problematic due to the different research designs and methodology. However, there is potential for generalisability between studies if common findings are presented and this difficulty acknowledged. Along with looking for common approaches such as the case study design to make comparisons between studies.

The obvious limitation to this study was the small sample size with ten patients and ten staff participating. However, with the wealth of information that has come from the case studies the author feels that its results can be generalisable to a wider population in another locality who are experiencing Intermediate care initiatives. This study presents rich qualitative data from the patient and staff experiences of different care pathways. Other localities will find this data extremely useful in designing or evaluating their services as it has been the service user that has provided feedback. However, the external validity of trying to generalise the findings across other care settings like nursing homes or day hospitals may be problematic.

Kohlbacher (2006) defines generalisability of a case study where the inferring process links to the theoretical reasoning which can be useful to understand the situation, intervention or phenomenon. Therefore, conclusions reached by extrapolating from data provide a greater understanding of the context, situation or the organisation. Given that this study is examining real life experiences in two different care settings of Secondary and Intermediate care, which are part of a complex organisation, the NHS, the results will give insight into how some of the system parts are functioning. Senge (2006) states that a whole system is affected by a change in one part where it has a knock on effect on the other parts in the system. Therefore, being able to provide care in the community saves on hospital bed days

and it is in this sense that the results of this study will be interesting to the NHS as a system.

A potential risk to this study was the lack of being able to identify suitable participants as quickly as hoped due to extenuating factors. These factors included the norovirus meaning wards were shut and there were fewer orthopaedic admissions to A & E to choose from. This barrier was overcome with the help of A & E staff and ERS staff who were able to assist with searching and introducing the research to potential participants whilst maintaining patient confidentiality and privacy.

It is important to note other issues that have arisen in this study which could warrant further investigation. These issues are systems theory, the study of organisations and change theory, but the author has been limited to a word count and to maintain a nursing theme throughout. Therefore, there are possibilities to explore other avenues of inquiry within this research topic which can further expand knowledge.

8.7 Further Research

Mentioned above is the possibility of other avenues of inquiry which have arisen in this research such as change theory or systems thinking theory. It has been important to retain a nursing emphasis in this study as justified by the patient suffering injury and needing to know the effects of that injury on their functioning and level of care needed. Therefore, to pursue other lines of enquiry would have lost the patient care focus. If further research was required then these avenues could be explored to add to what has already been discovered. Further research is needed on the whole NHS system effects of intermediate care initiatives like that chosen for this study, as the population residing in secondary care is changing due to providing community care for those who are suitable.

It was interesting that three out of ten patients had a prior bad experience of NHS hospital care. This influenced their opinion regarding staying in hospital. These patients formed part of the home care group and were very grateful that they could come home with support instead of stay in hospital. Intermediate care benefits

patients like these in providing them with an alternative option of care. However, it is the professionals' responsibility to regain trust in care delivery in order for the patient to make informed decisions regarding treatment so they are not putting their health at risk. It was incidental that this worrying statistic has occurred for the NHS as a whole and further research could be undertaken to discover the problems they encountered, the frequency of 'bad experiences' and any improvements that could be made to secondary care.

If there is a change in this service like expanding into facilitating more hospital discharges or providing a 24 hour service then further research would be advocated to examine the effects of these changes. Intermediate care is a flexible area of care that changes in response to demands placed upon it. Therefore, it is important to re-look at the research locality and surrounding areas as to what is taking place at the present. Also, if any changes have occurred from when this research was commenced.

The Early Response Service in the research locality was part of the Community Integrated Intermediate Services. This now has become part of a wider Community Resource Team as advocated by WAG (2010) incorporating more community services such as Continuing Health Care teams. The added benefit of this is that carers, therapists and nurses can be pooled to meet demand. It provides closer links between community teams who can inter-refer and advise the referrer at point of access the most suitable care pathway for the patient. The Early Response Service has also recruited more Health Care Support Workers with additional social services funds added to that of health. This has enabled the team to help target stroke patients in their transition from hospital to home care.

In an adjacent area to the research locality, the intermediate care team has set up telecare for patients at home with a rapid mobile response. Referrals are received through a single point of access system to make it easier for referrers. All resources within the community intermediate care are pooled and health and social services are working closer together (First Local Health Board, 2011). Another adjacent area

has close links with the day hospital and refers patients there for an urgent medical assessment by a doctor if needed.

Second Local Health Board (2011) has progressed on the 'Newtown Clinical Futures' (NHS Wales, 2006) with the establishment of Community Resource Teams in each locality including a single point of access for referrers. Also, by the opening of two new community rehabilitation hospitals in 2010 and 2011. In the next few years a specialist and critical care centre will be built to replace the larger secondary care hospital. This is part of the 'Newtown Clinical Futures' (NHS Wales, 2006) objectives to achieve care delivered as locally as possible and have one main critical centre. Therefore, it is important that those who can be treated in the community are identified and referred to the Community Resource Team. £9 million was given to this locality for their frailty programme as part of the 'invest to save' initiative by the Welsh Assembly Government.

The strategic vision for the Newtown Frailty Programme called 'Happily Independent' (Second Local Health Board, 2009) is to create an integrated model of community care. The service model contains three approaches of crisis intervention (up to 14 days), reablement and independent living (up to six weeks) and lastly longer term care. It is evident that each locality in Wales has created a Community Resource Team as set out in the policy, 'Setting the Direction' (WAG, 2010). This policy explains that the team will include those working in health and social care in the community and will be boosted over time with other primary care professionals like GPs and pharmacists. It acknowledges that there should be an all-Wales approach to Community Resource Teams regarding their governance standards of delivery and performance, but that the team also has to be responsive to local need. The aim is to provide a 24 hour community service by health and social care.

In the 'Third Local Health Board' an intermediate care team exists called East Locality Team. It provides virtual ward multidisciplinary support to individuals requiring increased health and social care input in the community (including care homes) to maintain and enhance recovery from acute problems. This team can also provide input to patients who are being discharged from hospital who need a similar

level of enhanced support (Third Local Health Board, 2011). Therefore, there are similarities with the Community Resource Team.

From the above information it is clear that Welsh localities are progressing towards a model of intermediate care inspired by policies such as, 'Setting the Direction' (WAG, 2010). Fragmented community health teams are now being joined together with social services to form the new Community Resource Team. It makes sense to have one single point of access for referrers in each locality. The referral can be screened and filtered through to the right professional or team who are able to respond. The aims of facilitating discharge and preventing inappropriate admissions will underpin these new teams' work. It will be exciting to undertake research on an all-Wales perspective as Community Resource Teams are becoming the standard arm of intermediate care in the community.

8.8 Dissemination of Findings

The researcher is guided by her sponsor's, The Band Trust, Florence Nightingale Foundation, advice regarding dissemination of findings by way of publication. Namely, the British Journal of Nursing and the International Practice Development Journal are helpful towards their scholars' publications. Thus, an article based on this research will be written and submitted imminently for publication. It is felt that publishing in these journals will allow access to any professional who performs a search for literature in reference to intermediate care. Full copies of the thesis will be disseminated to the manager of A & E and intermediate care in the chosen locality. The University where the researcher has studied will also have a copy of the final thesis and it will be offered to the Research and Development department in the research locality.

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APPENDIX 1

INTERMEDIATE CARE

CRITERIA

COMMUNITY INTEGRATED INTERMEDIATE CARE SERVICE (CIIS), ANYTOWN, REFERRAL CRITERIA

Adults living in City and County of 'Anytown' who have experienced a recent change in health or level of independence.

For example:

 Deterioration in physical health, personal activities of daily living, mobility, confidence or social circumstances, which has resulted in the loss of the ability to cope at home.

 Have experienced a reduction in their level of independence during an episode of hospital admission.

 Deterioration in physical health of clients in long term care.

And who also:

 Require a multi-disciplinary or interagency approach in order to optimize independence.

 Have the potential to improve and sustain **some or all** of their functional ability and independence with intensive short-term support within a period of usually up to 6 weeks.

 Are motivated with adequate cognitive skills to participate in order to achieve agreed goals.

EXCLUSION CRITERIA

 Individuals who are acutely unwell and require acute hospital treatment.

 Individuals who have significant mental health needs, requiring attention of specialist services.

SERVICE OBJECTIVES:

 To prevent avoidable acute hospital admissions and readmissions

 To prevent avoidable admission to long-term care homes.

 To provide support to achieve and sustain optimal independence after an episode of hospital or care home admission.

 To reduce ongoing dependency on community based services.

 To reduce the need for complex packages of domiciliary care.

APPENDIX 2
FAVOURABLE ETHICAL
OPINION



GIG
CYMRU
NHS
WALES

Canolfan Gwasanaethau
Busnes
Business Services
Centre

South West Wales REC

36 Or



Telephone: 01792 607418
Facsimile: 01792 607533

19 November 2010

Mrs Sera Manning



Dear Mrs Manning

Study Title: A Multiple Case Study of Patient Journeys from A & E to a Hospital Ward or to Home with the help of the Early Response Service.
REC reference number: 10/WMW02/28
Protocol number: unknown

The Research Ethics Committee reviewed the above application at the meeting held on 17 November 2010. Thank you for attending to discuss the study.

The Committee agreed that all issues raised with your previous application had been appropriately addressed and that no new issues had arisen. The Committee suggested some minor alterations to the information sheet however, these were not a condition for the favourable opinion.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Canolfan Gwasanaethau Busnes GIG Cymru,



Ffôn: 01792 607234
Ffacs yr hafan ddiogel: 01792 607234
TNT QW5/QW3 32



NHS Wales Business Services Centre,



Safe Haven Fax: 01792 607234
TNT QW5/QW3 32

rhan o Bwrdd Iechyd Lleol Addysgu Powys / part of Powys Teaching Local Health Board

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Information Sheet: staff	2	
Protocol	2	22 September 2010
CV - Jane Harden	1	
Participant Information Sheet: patients	2	
REC application	1	16 September 2010
Evidence of insurance or indemnity	1	27 July 2010
Investigator CV	1	
Covering Letter	1	09 October 2010

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

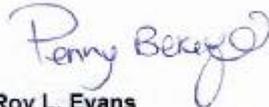
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/WMW02/28

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



 Roy L. Evans
Chairman

Enclosures:

List of names and professions of members who were present at the meeting and those who submitted written comments "After ethical review – guidance for researchers"

Copy to:

*Dr Jane Harden, School of Nursing, Cardiff University
R&D office for NHS care organisation at lead site*

APPENDIX 3 STAFF INTERVIEW SCHEDULE

INTERVIEW SCHEDULE FOR STAFF

Interviews will start in Autumn/Winter 2010 and take up to 6 months to complete. It is possible to undertake up to 4 a month i.e. 2 paired patients and the staff decision-maker(s). It may be that more participants are identified in one month and less in another, so the flexibility of a 6 month period is needed. It may be that a patient is interviewed twice dependent on their recovery time and a staff member may be interviewed more than once if they are involved in assessing the care of more than one patient in the study.

Staff Member Questions

1. In the case of patient A what factors were taken into account as to whether they could be cared for at home?
2. Likely answers may include service criteria, functional level, family support, pain, age, accommodation, medical history, transport, time of day, patients' choice, cognitive functioning and doctor's opinion. Can prompt these factors if they are not considered, and prompting may led to more discussion.
3. How was this person's self-care ability assessed?
4. Was there a multi-disciplinary input in this person's case?
5. Was there any input from the Early Response team at point of assessment e.g. finding out their capacity or checking if they had available staff or equipment?
6. Any equipment or resource issues that would have helped in this person's case?
7. What do you think would have happened if this patient took the opposite journey?
8. Do you believe this path was the one the patient wanted? Were they involved in the decision-making process?
9. Do you believe this path will lead to a quicker recovery for the patient?
10. What were the goals with this person?

APPENDIX 4
PATIENT INTERVIEW
SCHEDULE

INTERVIEW SCHEDULE FOR PATIENTS

Interviews will start in Autumn/Winter 2010 and take up to 6 months to complete. It is possible to undertake up to 4 a month i.e. 2 paired patients and the staff decision-maker(s). It may be that more participants are identified in one month and less in another, so the flexibility of a 6 month period is needed. It may be that a patient is interviewed twice dependent on their recovery time and a staff member may be interviewed more than once if they are involved in deciding the care of more than one patient in the study.

Patients Questions

1. How did you feel when you arrived at A & E?
2. What were your expectations? Home or to be admitted to hospital?
3. Did you feel part of the discussion on your care?
4. Do you disagree with the path that was considered best for you?
5. What circumstances would have made you want to take the other path?
6. Did you understand what was going to happen next? Expected recovery and follow-up appointments?
7. How has this injury/ illness affected you functionally?
8. How much help did you perceive you needed?
9. Compare to how much help they received.
10. Describe your experiences towards recovery? (probe any loneliness experienced)
11. Any regrets with the path of care you have received?
12. Did you in any way feel discriminated against with the choice of care at home or hospital that was offered to you? (Probe any age discrimination statements)
13. Would you do anything different if the same circumstances happened again?
14. How has this path been beneficial for you? Any areas you would like to improve?

APPENDIX 5 STAFF INFORMATION SHEET

PARTICIPANT INFORMATION SHEET – STAFF

Face to Face Interviews

Title of project: A Multiple Case Study of Patient Journeys from A & E to a Hospital Ward or to Home with the Support of the Early Response Service.

Introduction: You are being invited to take part in a research study which is towards obtaining a Doctorate in Nursing. Your participation is important because the investigator cannot understand the effects of different types of care without your help. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear to you, or if you would like more information please contact the investigator, Sera Manning. It is your decision to consider taking part.

What is the purpose of the study? The study aims to understand patient experiences of being cared for in hospital in comparison to being cared in the community with the help of the Early Response Service. The factors that aide recovery or hinder recovery will become evident and it is hoped this will give a better understanding of care delivery systems and how successful they are. Obviously, there are many patients who need to be admitted to hospital, for others they may be able to go home with help from health and social care professionals in their own environment.

How will the study be carried out? The study will consist of a 6 month period of interviewing 10 patients and 10 staff. Consent will be gained from patients to be interviewed about their care experiences and they must give consent before the member of staff who assessed them at A & E can be interviewed. If they do not give consent then the staff member will not be interviewed. The reason patients will be asked if they consent to staff being interviewed is because staff can bring up service and resource issues which will help and improve care delivery, but it is obviously their decision if they wish a member of staff to talk about their particular case. The aim is to discover how effective the Early Response Service is in facilitating discharges from A & E to prevent unnecessary hospital admissions and to clarify what type of patient they can help to go home with their care. All interview excerpts will be anonymised, so there will be no identifiable data in the study.

Why have I been chosen? You have been identified as the member of staff who assessed the patient at A & E and will know what factors were involved in determining their next care setting.

Do I have to take part? No, it's up to you whether you take part. If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason. However, if you decide to withdraw after the interview any data that is already collected may still be used. This is because the investigator will have already anonymised the transcripts. It will explain this on the consent form.

What will happen to me if I take part? You will be asked to sign a consent form to confirm you have read this information and are happy to take part. You will be given a copy of the consent form to keep, along with a copy of this information sheet. You will be asked to attend a face to face interview with the investigator, Sera Manning, at your work setting or a quiet room in the hospital. The date and time of the interview will be mutually agreed. The interview is anticipated to last a maximum of one hour.

What are the possible risks or disadvantages of taking part? There is no evidence to suggest that taking part in the face to face interview will expose you to any risk of harm. You will be free to leave at any time without an explanation. Your working role will not be affected if you decide to part or not.

What are the benefits of taking part? The information gathered by the study will help future patients understand the care they receive and different types of care available to them. It will help professionals by attaining a better understanding of the service we provide and how successful it is. The study may help service providers in deciding the best utilisation of resources if a particular care pathway works or help identify improvements in service provision.

Will I be paid for taking part? There is no direct payment for taking part.

How can I find out the results of the study? At interview you will be asked if you would like to be kept informed of the results.

What if something goes wrong? If taking part in this study harms you in any way there are no special arrangements for compensation. If you are harmed by someone else's negligence then you may have grounds for legal action, but you may have to pay for it. Regardless of this, if you have any concerns or wish to complain about any aspect of this study, then the normal National Health Service complaints mechanisms will be available to you. Cardiff University is covered by indemnity insurance.

Will my part in the study be confidential? All information that is collected about you during the study will be kept strictly confidential. This information will be stored securely on paper and electronically under the provisions of the Data Protection Act (1998). Anything you say at interview or excerpts from the transcripts of the interviews that are quoted in study reports will be made anonymous, so that the person who gave the information cannot be identified. No actual sound recordings of the interviews will be used in reports or publications. They will only be used by the investigator to create accurate transcripts of interviews then destroyed.

What will happen to the results of the study? The results of this study will be published as a Professional Doctorate thesis (a higher University qualification). Results will also be available to the Local Health Board and Intermediate Care. It may be that extracts are published in peer review nursing journals. You will not be identified in any way in any report or publication arising from the study. You can choose to receive a summary of the results of the study.

Who is organising the funding of the study? The study is funded by the investigator herself and the kind sponsorship of The Band Trust at The Florence Nightingale Foundation, London.

Who has reviewed the study? The study proposal has been submitted to the South West Wales Research and Ethics Committee and Cardiff University for ethical

approval. It has also been approved by the Research and Development department in the Health Board. The managers of the two service areas being studied will also have had an opportunity to review the study i.e. A & E Manager and Intermediate Care Manager.

Contact Information:

Name of Investigator: Sera Manning

Contact Department: Anytown

Telephone:

E-Mail:

THANK YOU FOR TAKING THE TIME TO READ THIS

APPENDIX 6
PATIENT INFORMATION
SHEET

PARTICIPANT INFORMATION SHEET – PATIENTS

Face to Face Interviews

Title of project: A Multiple Case Study of Patient Journeys from A & E to a Hospital Ward or to Home with the Support of the Early Response Service.

Introduction: You are being invited to take part in a research study which is towards obtaining a Doctorate in Nursing. The investigator cannot understand the effects of different types of care without your help. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear to you, or if you would like more information please contact the investigator, Sera Manning. It is your decision to consider taking part.

What is the purpose of the study? The study wants to understand patient experiences of being cared for in hospital compared to being cared for at home with the help of the Early Response Service. The Early Response team links in with A & E to see if there are any patients suitable to be cared for at home. It will be interesting to find out the different experiences of patients with the same/similar injuries who either end up being admitted to a ward or discharged home with the care of the Early Response Service. What helps patients make a recovery from an injury/illness will be interesting to discover and also if there is anything health services can do to help you achieve independence again. Obviously, there are many patients who need to be admitted to hospital, for others they may be able to go home with help from health and social care professionals.

How will the study be carried out? The study is 6 months long where 10 patients and 10 staff will be interviewed. The investigator will introduce herself to you at A & E and ask if you want to take part. If so, you will need to give consent to the investigator to have your contact details to arrange an interview time around a month later. You will also be asked if you consent to the staff member who assessed you can be interviewed. If so, they will be interviewed after you are, just in case you change your mind. You are only being asked if the staff member can be interviewed because they can say what things were needed in the community that would have helped you go home. When the interview takes place the investigator will write it up and anonymise it, so any excerpts (things you say) used in the study will not be traced back to you.

The staff will not be allowed your name or personal details either. You will be given a number or letter.

Why have I been chosen? You will have been chosen to be asked because you have gone to A & E with an injury/ illness. The investigator does not know what happened to you and has not accessed your medical records. The investigator will ask your permission to know more about you.

Do I have to take part? No, it's up to you whether you take part. If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason.

What will happen if I don't want to carry on with the study? You can withdraw from the study at any time. However, if you withdraw after the interview any information collected from interview may still be used as it would have been anonymised. The investigator will not know who said what to take it out.

What will happen to me if I take part? You will be asked to sign a consent form to confirm you have read this information and are happy to take part. You will be given a copy of the consent form to keep, along with a copy of this information sheet. You will then be asked to attend a face to face interview with the investigator, Sera Manning, at your home or a quiet room in the hospital. The date and time of the interview will be agreed with you. The interview will last one hour.

What are the possible risks or disadvantages of taking part? There is no evidence to say that taking part in the face to face interview will cause you any harm. You will be free to leave at any time without an explanation.

What are the benefits of taking part? We want your opinion. You are helping patients understand the care they have and different types of care available to them. It will help staff see what type of patients they can send home with help from

community teams and how they can improve this service. It will help show what patients have to be admitted to hospital for their care.

Will I be paid for taking part? There is no direct payment for taking part.

How can I find out the results of the study? At interview you will be asked if you would like to be kept informed of the results.

What if something goes wrong? If taking part in this study harms you in any way there are no special arrangements for compensation. If you are harmed by someone else's negligence then you may have grounds for legal action, but you may have to pay for it. Regardless of this, if you have any concerns or wish to complain about any aspect of this study, then the normal National Health Service complaints mechanisms will be available to you. Cardiff University is covered by Indemnity Insurance.

Will my part in the study be confidential? All information that is collected about you during the study will be kept strictly confidential. This information will be stored securely on paper and electronically under the provisions of the Data Protection Act (1998). Anything you say at interview or excerpts from the transcripts of the interviews that are in study reports will be made anonymous, so that the person who gave the information cannot be identified. No actual sound recordings of the interviews will be used in reports or publications. They will only be used by the investigator to create accurate transcripts of interviews then destroyed.

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Who has reviewed the study? The study proposal has been submitted to the South West Wales Research and Ethics Committee and Cardiff University for ethical approval and review by the Research and Development department. The managers of the two service areas being studied will also have had an opportunity to review the study i.e. A & E Manager and Intermediate Care Manager.

Contact Information:

Name of Investigator: Sera Manning

Contact Department: Anytown

Telephone:

E-Mail:

THANK YOU FOR TAKING THE TIME TO READ THIS

APPENDIX 7

STAFF CONSENT FORM

APPENDIX 8

PATIENT CONSENT FORM

PARTICIPANT CONSENT FORM – PATIENTS

Face to Face Interviews

Title of Project: A Multiple Case Study of Patient Journeys from A & E to a Hospital Ward or to Home with the Support of the Early Response Service.

Name of Investigator: Sera Manning

PLEASE **INITIAL** THE FOLLOWING BOXES:

I confirm I have read and understood the information sheet for the study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that if I withdraw from the study any data that has already been collected will be kept.

I agree to be tape recorded during the interview. Tape recordings will only be listened to by the investigator in order to make accurate notes of the discussion.

I agree to take part in the above study where everything I say in the interview will be anonymised if direct quotes are used.

I agree to the investigator interviewing the member of staff who assessed me in A & E. My personal details will not be disclosed in this interview.

On day of interview: Do you still consent to the member of staff who assessed you to be interviewed? PLEASE CIRCLE YES/NO

.....
Name of Participant Date Signature

.....
Researcher/Investigator Date Signature

Sera Manning

.....
YOUR CONTACT DETAILS: Name
Address
.....Postcode
Contact Telephone Number

THANK YOU FOR YOUR HELP

1 copy for participant: 1 copy for researcher