Recovery Following Hip Fracture Surgery for Older People Living in Rural Areas

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Abstract

A hip fracture due to a fall is one of the most common and severe health issues affecting older people, and this may present special challenges for older people living in rural areas. The overall aim of this licentiate thesis was to describe recovery after a hip fracture for older people living in rural areas. Data were collected with qualitative individual interviews with 13 older people who were recovering from hip fracture surgery in their own home (I) and with focus group interviews with 18 nurses working at an orthopedic unit (II). In both studies, the data was analyzed using qualitative content analysis (I, II). This study shows the importance of older people receiving support and information as well as being able to participate in their own care when recovering after hip fracture surgery. Since recovery begins in the hospital, the orthopedic nurses play a key role in enabling the older person to regain mobility and independence. The findings show that older people described finding themselves in a new and vulnerable situation in which they were dependent upon others for simple everyday chores they used to take for granted. They struggled to regain independence while staying positive and convinced that they would recover. They felt grateful that they had been able to return to their own home after discharge from the hospital. Fear of another fall as well as lack of information made the recovery at home difficult (I). The findings also show that the nurses believed that patients need support from healthcare personnel as well as relatives in order to prepare for a life at home and they did their best to support them. They expressed that both patients and they themselves had difficulty influencing several aspects surrounding discharge planning, such as participating in decision making (II). In conclusion, the findings of this thesis show that to suffer an acute life-altering event has a great impact on the affected person’s daily life. However, it seems that they are given rather small opportunities to participate in and influence decision making during discharge planning. Healthcare personnel need to see the individual and provide sufficient information in order for them to participate during care and feel safe after they are discharged from the hospital. The rural context did not seem to affect the older person’s experiences of recovery or the way in which nurses made discharge plans. What seemed to be most important to the older people living in rural areas was the fact that they were able to return to their own home. For the nurses, it seemed that patients who were perceived as lonely, without a social support system around them, was a greater concern than the geographic location of their home.
Key words: discharge planning, experiences, hip fracture, hospital care, nurses, older people, own home, participation, recovery, rural area, transition, qualitative content analysis
Återhämtning efter en höftfrakturooperation för äldre personer som bor i glesbygd.

Varje år drabbas cirka 18000 personer i Sverige av en höftfraktur (Rikshöft, 2016) och det gör höftfrakturerorskad av ett fall till något av de vanligaste och mest allvarliga som kan drabba en äldre person. Tidigare forskning visar att drabbas av en höftfraktur kan påverka den drabbade personen såväl fysiskt som psykiskt för en lång tid framåt. Återhämtning efter en höftfraktur är en komplex och subjektiv upplevelse där den drabbade är starkt beroende av familj, grannar och formella vårdgivare på grund av nedsättning av den fysiska funktionsförmågan. Eftersom återhämtningsperioden startar på sjukhuset spelar sjuksköterskor en nyckelroll i att hjälpa patienterna att återfå mobilitet och oberoende.

Beroendet av andra samt den nedsatta funktionsförmågan skulle kunna innebära speciella utmaningar för äldre personer som bor i glesbygd eftersom det ofta saknas affärer, kollektivtrafik samt specialiserad häls- och sjukvård i dessa områden. Det finns mycket lite forskning om äldre personers erfarenheter av att återhämta sig efter en höftfraktur i eget hem i glesbygd, därför har denna licentiatavhandling fokus på den rurala kontexten. Det övergripande syftet för denna licentiatavhandling var att beskriva återhämtning efter en höftfraktur för äldre personer som bor i glesbygd. Denna licentiatavhandling består av två delstudier. Den första delstudien fokuserade på att beskriva äldre personers upplevelser av återhämtning efter en höftfraktur i eget hem i glesbygd (I), medan fokus i den andra delstudien var att beskriva sjuksköterskors syn på att planera utskrivning för äldre patienter som opererats för höftfraktur och ska skrivas ut till eget hem i glesbygd (II), se Tabell 1.
Tabell 1
Översikt över delstudiernas syfte, design/metod, deltagare och datainsamling

<table>
<thead>
<tr>
<th>Studie</th>
<th>Syfte</th>
<th>Design/Metod</th>
<th>Deltagare</th>
<th>Datainsamling</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Att beskriva äldre personers erfarenheter av återhämtning i eget hem i glesbygd efter en höftfrakturoperation</td>
<td>Kvalitativ metod/kvalitativ innehållsanalys (Catanzaro, 1988)</td>
<td>13 äldre personer</td>
<td>Individuella intervjuer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kvinnor=7 Män=6</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Att beskriva sjuksköterskor på en ortopedavdelningens syn på att planera utskrivning för äldre personer som opererats för en höftfraktur och ska skrivas ut till eget hem i glesbygd</td>
<td>Kvalitativ metod/Kvalitativ innehållsanalys (Catanzaro, 1988)</td>
<td>18 sjuksköterskor</td>
<td>Fokusgrupps intervjuer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kvinnor=14 Män=4</td>
<td></td>
</tr>
</tbody>
</table>

Till delstudie I insamlades data med kvalitativa individuella intervjuer med 13 äldre personer över 65 år, som återhämtade sig i eget hem efter en höftfrakturoperation. Intervjuerna genomfördes i de äldre personernas hem cirka tre till fem veckor efter utskrivning från sjukhuset. En intervjuguide användes och deltagarna tillfrågades om fallet samt hur deras liv var nu i jämförelse med före frakturen. De tillfrågades även om sjukhusvistelsen och i vilken utsträckning de var delaktiga i planering för utskrivning. Intervjuerna spelades in digitalt och skrevs ut ordagrant. Texterna analyserades med kvalitativ innehållsanalys och resulterade i fyra teman, se Tabell 2.

Till delstudie II insamlades data med fokusgruppsintervjuer. Sammanlagt 18 sjuksköterskor på en ortopedisk vårdavdelning med erfarenhet av att planera utskrivning för äldre personer som opererats för höftfraktur deltog indelade i 4 grupper. En vinjett användes för att stimulera fokusgruppintervjuerna. Vinjetten beskrev ett fiktivt patientfall om en äldre, ensamboende kvinna i glesbygd som ådragit sig en höftfraktur och vårdades på en ortopedisk vårdavdelning. Deltagarna ombads sedan berätta hur de skulle planera utskrivning för patienten. Därefter tillfrågades de om utskrivningsplanering generellt för patienter med höftfraktur som ska skrivas ut till hemmet i
glesbygd samt patientens och anhörigas delaktighet i denna planering. Fokusgruppsintervjuerna spelades in digitalt och skrevs ut ordagrant. Texterna analyserades med kvalitativ innehållsanalys och resulterade i ett tema och fyra kategorier, se Tabell 2.

Tabell 2
Översikt av teman och kategorier

<table>
<thead>
<tr>
<th>Studie</th>
<th>Teman</th>
<th>Kategorier</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>En oväntad livsförändrande händelse</td>
<td>Att stötta</td>
</tr>
<tr>
<td></td>
<td>Förbereda sig för att åka hem</td>
<td>Att involvera närstående</td>
</tr>
<tr>
<td></td>
<td>Behov av förändring och stöd hemma</td>
<td>Inte alltid fokus på patientens behov</td>
</tr>
<tr>
<td></td>
<td>Att kämpa för att klara sig hemma</td>
<td>Svårigheter att påverka</td>
</tr>
<tr>
<td>II</td>
<td>En spindel i ett trasigt nät</td>
<td></td>
</tr>
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</table>

Resultatet i delstudie I visar att de äldre personerna beskrev att de i och med fallet som orsakade höftfrakturen drabbats av en oväntad livsförändrade händelse. De hade hamnat i en ny och sårbar situation där de var beroende av andra för att utföra enkla vardagliga saker som de tidigare tagit för givet. Det var inte roligt att behöva hjälp men de accepterade det eftersom det inte fanns något alternativ. De var nöjda med vården och tyckte att personalen var snäll och hjälpsam, men de kände inte att vården de fick var anpassad efter deras behov utan att saker och ting mer skedde på rutin. Samtidigt som de kämpade med att återfå oberoende, vissa otåligare än andra, var de positiva och övertygade om att de skulle återhämta sig. De var också tacksamma över att de hade kunnat komma tillbaka till sitt eget hem efter utskrivning från sjukhuset och beskrev att det inte hade gått om de inte haft ett stort stöd från familj, vänner och bekanta samt den kommunala hemtjänsten. Rädsla för att falla igen samt brist på information gjorde att det var besvärligt att klara sig hemma. Höftfrakturen hade också inneburit att de nu blivit mer ödmjuk inför livet och det faktum att det snabbt kan förändras.
Resultatet i delstudie II visar att sjuksköterskorna ansåg att patienterna behöver stöd från hälso- och sjukvårdspersonal för att förbereda sig för att bli utskriven från sjukhuset och de gjorde sitt bästa för att uppmuntra och stödja patienterna till att återfå oberoende. Sjuksköterskorna såg den äldre patienten med en höftfraktur som en stark individ som kunde ha svårt att acceptera att den nu behövde hjälp, och tog därför tidigt under vårdtiden upp att de kunde få hemtjänst efter utskrivning om de hade behov av det. De ansåg också att närstående var ett viktigt stöd under vårdtiden och de flesta upplevdes osjälviska och var ofta villiga att hjälpa och stödja den drabbade familjemedlemmen mer än vad sjuksköterskorna tyckte förväntas av dem. Sjuksköterskorna uttryckte att samarbetet med annan hälso- och sjukvårdspersonal, både inom och utom den egna organisationen, hade försämrats under de senaste åren vilket i sin tur påverkade utskrivningsplaneringen negativt.

List of papers

This licentiate thesis is based on the following papers, which will be referred to in the text by their Roman numerals:

I  Segevall, C., Söderberg, S., & Björkman-Randström, K. (resubmitted). The journey towards taking the day for granted again - older peoples' experiences of recovering from a hip fracture in rural areas.


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Definitions

Discharge planning - A process that seeks to coordinate a patient’s future care, during and beyond a hospital stay (Bull & Roberts, 2001)

Hip fracture – A generic name for three different types of fractures in the proximal femur area (Altizer, 2005).

Older people - People 65 years of age or older (Sabharwal, Wilson, Reilly, & Gupte, 2015)

Recovery - The process of learning to live in a new way after an acute, life-altering event or chronic disease (Anthony, 1993; Godfrey & Townsend, 2008)

Transition - A period between two relatively stable periods in life (Meleis, 2010)

Rural area - A countryside with a population density of ≤ 5 inhabitants per square kilometer (Jordbruksverket, 2013)
Introduction

This licentiate thesis focuses on recovery after a hip fracture for older people living in rural areas. Nurses have a pivotal role in making discharge plans together with their patients to assure a successful re-entry into their homes. Hence, good or bad discharge planning has consequences for recovery. Every year approximately 18,000 people in Sweden suffer a fall-related hip fracture (Rikshöft, 2016). Hip fracture rates are predicted to continue rising in the developed world because of the aging population (Marks, 2010; Rosengren, Björk, Cooper, & Abrahamsen, 2017). The Swedish hip fracture care program involves a short time between admittance to hospital and surgery, early mobilization, and continuing rehabilitation in the affected person’s home, with or without the help of a physiotherapist. As a result, the length of the hospital stay has been shortened. The goal is that the person who suffered the fracture will regain the level of function and quality of life he or she had prior to the fracture (Rikshöft, 2016). Thus, it is central to gain more knowledge about patients’ experiences of recovery after a hip fracture and nurses’ experiences of nursing care for recovery after a hip fracture.

Background

Being an older person living in a rural area

The increasing population of older people is a noted domain that challenges health care and social services around the world. The challenge is greater for rural areas than urban areas because of the lack of access to specialized health care (Hanlon & Kearns, 2016). This can be problematic for older people since they often have more complex health issues than younger people (Scharf, Walsh, & O’Shea, 2016). Migration patterns have changed in several countries throughout the world during the last decades. This has led to the fact that rural, relatively remote and sparsely populated areas, typically have the highest proportions of older people (Burholt & Dobbs, 2012). In Sweden and many other countries, there is a range of definitions for a rural area. The definition used in this licentiate thesis refers to a rural area as a countryside with a population density of ≤ 5 inhabitants per square kilometer (Jordbruksverket, 2013).
Defining when a person is considered old is complex and multidimensional. In many countries, a person is considered old when he or she reaches age 65, but this view is often disputed because of improving life expectancy, quality of life, and level of function within an aged population (Sanderson & Scherbov, 2008). Old can also be described as the age at which a person is entitled to state pensions (United Nations [UN], 2012). In orthopedic research, the most commonly used definition at which a person is considered old is 65 years of age, based on chronological age measures alone (Sabharwal et al., 2015). In this thesis, people 65 years of age or older will be defined as “old.”

There are positive and negative aspects of living in a rural area when old. On one hand, it has been described as being close to family and friends and having an informal support system where neighbors help each other with everything, from paying attention to whether or not the lights turn on and off at the right times to an organized washing service (King & Farmer, 2009). On the other hand, older adults who live in a rural area may become isolated in their homes because they may be unable to drive and there is limited availability of public transportation (Baernholdt, Yan, Hinton, Rose, & Mattos, 2012). A general lack of service infrastructure, such as insufficient health and social care services as well as poor retail services has also been described as problematic in rural areas (Scharf et al., 2016).

The occurrence of fall-related hip fractures in older people

Every third person over 65 years of age who lives at home has at least one falling accident per year, and for older people, most of these falls occur indoors (Peel, 2011). The risk factors for suffering a fracture due to a fall are well known. Mostly it is a result of a combination of risk factors, such as age, gender, previous falling accidents, osteoporosis and lifestyle factors, such as smoking and lack of physical activities (Ambrose, Paul, & Hausdorff, 2013). Roughly four to six percent of all falls result in a serious injury such as a hip fracture (Peel, 2011).

Approximately 1.7 million hip fractures occur worldwide each year (International Osteoporosis Foundation, 2017) and that makes hip fractures one of the most common reasons for hospital admission for men and women over 65 years of age (Parker & Johansen, 2006). Hip fracture rates vary among different countries with the highest numbers found in the United States and
In Sweden, the mean age of people who suffer a hip fracture is just above 80 years old (Rikshöft, 2016), but the risk of being affected, especially as a woman, increases at 50 years of age (Cummings & Melton III, 2002). About 70 percent of those affected are women, but in the last couple of years, there has been a noticeable increase among men (Enseki & Read, 2013). Hip fractures are also referred to as “fragility fractures” and defined by any low trauma fracture such as fall from a standing height or lower (Curtis et al., 2017).

Hip fracture is a generic name for three different types of fractures in the proximal femur area: femoral neck fracture, trochanteric fracture, and subtrochanteric fracture (Altizer, 2005). The surgical methods vary depending on the type of hip fracture. Trochanteric and subtrochanteric fractures are commonly stabilized with screws and plates or intra-medullary nails, depending on fracture fragmentation, while hemiarthroplasty is used for stabilization of a femoral neck fracture (Parker, 2010). In recent years, efforts have been made worldwide to provide guidelines to improve the quality of acute care for patients with hip fracture and secondary prevention to prevent subsequent falls and fractures (Mitchell et al., 2016). Fall risk prevention, such as medication adjustments, behavioral instructions, and exercise programs can reduce the risk of falling among older people (Ambrose, Cruz, & Paul, 2015).

Daily life of older people suffering a hip fracture
A hip fracture due to a fall is one of the most severe health issues that affect older people (Parker & Johansen, 2006). For most people, suffering a hip fracture is a trauma to the individual and creates a sense of losing control over one’s life (Archibald, 2003; McMillan, Booth, Currie, & Howe, 2012). Others consider a hip fracture to be a natural part of aging and accept that there is nothing they can do about it (Roe et al., 2009). A review by Peeters et al. (2016) shows that older people’s health status and health-related quality of life are seriously affected by a hip fracture physically, psychologically, and socially. Pre-fracture functioning, psychological state, comorbidity, female gender, length of hospital stay, and complications are associated with a worse outcome.
Approximately one-third of the people who live in their own home prior to the hip fracture return to their ordinary living accommodations; the remaining two-thirds enter a nursing home for the first time. For some this is a temporary accommodation during recovery, but others never return to their home (Rikshöft, 2016). The risk of dying also increases when a person suffers a hip fracture and can be seen as a result of age and comorbidities, and often occurs within the first year after the fracture (Haentjens et al., 2010). A hospital stay shorter than ten days is also associated with an increased risk of dying within the first 30 days post-discharge (Nordström, Gustafson, Michaëlsson, & Nordström, 2015).

Several studies show that fear of suffering another fall is common among people who have experienced a hip fracture (Archibald, 2003; Bergeron, Friedman, Messias, Spencer, & Miller, 2016; Hommel, Kock, Persson, & Werntoft, 2012). Fear of falling may lead to reduced compliance to physical rehabilitation (McMahon, Talley, & Wyman, 2011), which in turn can lead to a poorer functional recovery (Pauelsen, Nyberg, Röijezon, & Vikman, 2017) resulting in isolation (Jellesmark, Herling, Egerod, & Beyer, 2012). In a review by Visschedijk, Achterberg, Van Balen, and Hertogh (2010), fear of falling is described to be even more important for recovery after a fracture than pain management and depression due to the loss of independence.

To be dependent on others during recovery after a hip fracture

For many older people it is difficult to imagine a life in which they are unable to get by on their own, depending on others for simple daily activities (King & Farmer, 2009). To be dependent on help from family members and being dependent on care has been associated with feelings of helplessness and powerlessness (Holm & Severinsson, 2013). Hence, to be independent and have autonomy is important to older people (Bergeron et al., 2016; King & Farmer, 2009; McMillan et al., 2012).

Suffering a hip fracture affects the individual both physically and psychologically for a long period of time (Rasmussen & Uhrenfeldt, 2016), sometimes more than a year (Zidén, Scherman, & Wenestam, 2010). Recovering from a hip fracture is a complex and subjective experience and the
dependence upon family, neighbors, or formal caregivers is large due to the physical impairment that follows (Healee, McCallin, & Jones, 2017; Rasmussen & Uhrenfeldt, 2016).

Recovery can be described as the process of learning to live in a new way after an acute, life-altering event or chronic disease. It does not have to be a life without symptoms or limitations but rather finding new ways of perceiving, interacting, and managing with one’s surroundings (Anthony, 1993; Godfrey & Townsend, 2008). Recovery also involves a gradual process of “getting back to normal,” which includes assessing and reflecting on one’s physical and emotional needs as well as engaging in rehabilitation (Bergeron et al., 2016). A number of factors are suggested to influence recovery, such as surgery and treatment interventions, nursing factors (Mouzopoulos et al., 2008), the person’s activity level and walking ability prior to the hip fracture, as well as age (Lin & Chang, 2004).

People who suffer a hip fracture are aware that it will take time and energy to recover and they have a strong inner drive to regain independence (Gesar, Hommel, Hedin, & Bååth, 2017). Thus, they are not necessarily prepared for the need for help (Forsberg, Söderberg, & Engström, 2014; Healee et al., 2017) with even the simplest things in daily life, like bathing, grooming, walking on flat ground, and walking up and down stairs (Wu et al., 2013). During recovery, older people think that it is important to have a positive attitude since they believe that this can enhance recovery (Healee et al., 2017). However, when recovery is perceived as slow, the older person can start to lose faith in his or her own capacity to regain independence, and, therefore, give up on their efforts to do so (Gesar, Bååth, Hedin, & Hommel, 2017).

**Nursing care for people suffering a hip fracture**

Management of patients with hip fractures should optimize outcome after discharge from the hospital. This involves several stages of care, beginning before the patient is admitted to the hospital and ending after discharge (Rikshöft, 2016). The primary goal of nursing care for the older adult with a hip fracture is to maximize mobility and preserve optimal function (Maher et al., 2012). To achieve this, nurses should, among other things, monitor for signs of anemia (which could interfere with the patients’ ability for early mobilization), monitor the patients’ nutritional status (Maher et al., 2013), and
supply sufficient pain medication (Shyu, Chen, Chen, Wu, & Su, 2009). Another important part of nursing care is to make the patient participate in, and make decisions about his/her care (Castro, Van Regenmortel, Vanhaecht, Sermeus, & Van Hecke, 2016). Patient participation builds upon a dialogue between the nurse and the patient in which knowledge is shared and the patient is enabled to participate (Eldh, Luhr, & Ehnfors, 2015). The nurse-patient relationship is an essential component in which the nurse connects with the patient as human and equal, showing respect and genuine engagement (Angel & Frederiksen, 2015).

Nurses are responsible for the coordination of the patient’s discharge planning, which begins at admittance by conducting initial assessments that inform decisions about who should be involved (Rhudy, Holland, & Bowles, 2010). Discharge planning can be defined as a process that seeks to coordinate a patient’s future care, during and beyond hospitalization (Bull & Roberts, 2001), and involves a collaboration of various members of the healthcare team, including physicians, nurses, physiotherapists, and occupational therapists, as well as patients and their relatives. In case the patient is in need of help from municipal social service after discharge, a social worker from the municipality also participates (National Board of Health and Welfare, 2005). Essential elements of effective discharge planning include effective communication, a multidisciplinary approach, and early and coordinated assessments of patients’ needs and home circumstances (Bull & Roberts, 2001).

The length of the hospital stay after hip fracture surgery has decreased drastically over recent years and the average length in Sweden is now 8.3 days (Rikshöft, 2016). Research has shown that patients want to be discharged to their own home after a hospital stay, since they believe it is the best place for their recovery (Gabrielsson-Järhult & Nilsen, 2016; Randström, Asplund, Svedlund, & Paulson, 2013). However, it is common for patients to feel nervous and worried when it comes to discharge. Often they think they are not ready and the discharge is too early (Hommel et al., 2012; Toscan, Manderson, Santi, & Stolee, 2013).

Discharge planning is a vulnerable part of the hospital stay, especially for older people who often suffer from physical and/or cognitive disabilities (Coffey, 2006). Involving older patients in planning and decision making during a hospital stay strengthens their ability to manage their daily life post-
discharge (Lyttle & Ryan, 2010). When decisions regarding discharge planning are made without the patient’s involvement, there is a risk that the patient will not manage at home since they have not been given the opportunity to assess their ability to do so (Alharbi, Carlström, Ekman, Jarneborn, & Olsson, 2014). Several studies show that patients and family members do not always feel that they are involved in the discharge process (Dyrstad, Laugaland, & Storm, 2015; Malmgren, Törnvall, & Jansson, 2014). Neither do they think that they receive sufficient information about what will happen after discharge or how they will cope with the practical aspects of daily living (Allen, Hutchinson, Brown, & Livingston, 2017; Elliott, Forbes, Chesworth, Ceci, & Stolee, 2014; Schiller et al., 2015).

Recovery – a transition in daily life after a hip fracture

When a person experiences a change in health and illness, such as a hip fracture, a process of transition begins. Hence, the recovery for older people suffering a hip fracture can be viewed as a process of transition. A transition can be described as a period between two relatively stable periods in life and involves adaptation and adjustment to a new situation. People in transition tend to be vulnerable, which may affect their health. Transitions that can make people vulnerable include illness experiences such as diagnosis, surgical procedures, rehabilitation, and recovery. Vulnerability is related to transition experiences, interactions, and environmental conditions that expose individuals to damage, problematic or extended recovery, or delayed or unhealthy coping. Transitions are characterized by their uniqueness, complexity, and multiple dimensions. Properties such as awareness, engagement, change and difference, time span, and critical points and events have been identified as vital. A healthy completion of a transition is determined by the extent to which individuals manage to master the new skills and behaviors needed for their new situations or environment. Nurses tend to be the caregivers who prepare patients for impending transitions and who facilitate the process of learning new skills related to the their health and illness experiences. To understand the experiences of patients during transition, it is necessary to uncover the conditions that facilitate or constrain the processes of healthy transitions and the outcome of transition (Meleis, 2010).
Rationale for the study

Although there is a focus on fall prevention, hip fracture rates are increasing. The existing research about older people recovering from a hip fracture mostly focuses on functional recovery, post-operative pain, and the impact a hip fracture can have on health-related quality of life. There are also studies that describe older people’s experiences of recovery after a hip fracture, but very few have an explicit rural context. Since suffering a hip fracture can lead to a temporary or permanent loss of independence, where the affected people need help managing activities in daily life for a long period after discharge from the hospital, this may be especially challenging for people living in rural areas. Since hospital stays are getting shorter and the affected person is given less time to prepare for a life at home, nursing care and discharge planning is pivotal. The knowledge from this licentiate thesis can be used for improving care after a hip fracture for older people living in rural areas so it is better aligned with their needs.
The aim

The overall aim of this licentiate thesis was to describe recovery after a hip fracture for older people living in rural areas. From the overall aim, the following specific aims were formulated:

- to describe older people’s experiences of recovering after hip fracture surgery while living in rural areas (I).

- to describe nurses’ views on discharge planning for older patients after hip fracture surgery who live in their own homes in rural areas (II).

Methods

The naturalistic perspective

This licentiate thesis is within the naturalistic perspective, as its intention is to describe the experiences of older people’s recovery following hip fracture surgery and nurses’ views on discharge planning concerning these people. Research within the naturalistic perspective takes place in real-world settings (Patton, 2015), which are also called ‘natural settings’ (Lincoln & Guba, 1985), and is based on the notion that context is essential for understanding human behavior. Furthermore, research that adopts a naturalistic perspective focuses on participants’ own experiences and therefore researchers must meet participants where they are so that data collection occurs while people are engaging in their everyday practices. The phenomenon of interest unfolds naturally through observations or interviews with open-ended questions in places where and conditions under which participants feel comfortable (Patton, 2015).

Context

Both studies in this licentiate thesis have been carried out in a region in the middle of Sweden mostly consisting of rural areas. One hospital supplies healthcare to this entire region. The region has a population density of 2.7 inhabitants per km² (Statistiska centralbyrån, 2018). Every year, approximately 18,000 people in Sweden suffer a fall-related hip fracture. In
the region investigated, approximately 300 patients, most of them older than 65 years (M=81.4), undergo surgery for a hip fracture every year. Of the affected people, 65% are women and about half of them lived alone prior to the fracture. The average length of the hospital stay after hip fracture surgery at the hospital investigated is 9.3 days, which is slightly more than the Swedish national average of 8.3 days (Rikshöft, 2016).

Discharge planning can be structured differently in different parts of Sweden. At the orthopedic unit in the hospital investigated, a discharge-planning nurse coordinates the discharge planning. The discharge-planning nurse gathers information about the patient’s capacity to return home in collaboration with the other nurses at the unit as well as from the patient and their relatives. If a patient requires help at home after discharge, the discharge-planning nurse notifies the discharge planning team from the patient’s municipality and books a discharge planning meeting. Otherwise, discharge planning is made in dialogue with patients and relatives. If the patient lives in the municipality where the hospital is located, a discharge-planning meeting with the municipal discharge planning team will be held at the hospital a couple of days prior to discharge; otherwise, the meeting is held via telephone. The municipal discharge planning team consists of a social worker, a district nurse, a physiotherapist and an occupational therapist.

In the study presented in Paper I, older people recovering from hip fracture surgery were included. In Paper II, nurses working at the orthopedic unit were included.

**Design**

A qualitative design was chosen for both studies in this licentiate thesis. Qualitative studies provide us with detailed, deep knowledge of what is being studied; it gives us an answer to what people feel, think, and experience. The sample is typically relatively small and selected purposefully to permit inquiry into and understanding of the area of research focus (Patton, 2015). In the study presented in Paper I, the focus was older people’s experiences of recovering after hip fracture while living in rural areas. In the study presented in Paper II, the focus was the nurses’ views on discharge planning for older patients after hip fracture surgery who live in their own homes in rural areas (Table 1).
Table 1
Overview of the studies

<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Method</th>
<th>Data collection methods</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>To describe older people’s experiences of recovering after hip fracture surgery while living in rural areas.</td>
<td>Qualitative</td>
<td>Individual qualitative interviews</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td>II</td>
<td>To describe nurses’ views on discharge planning for older patients after hip fracture surgery who live in their own homes in rural areas.</td>
<td>Qualitative</td>
<td>Focus group interviews</td>
<td>Qualitative content analysis</td>
</tr>
</tbody>
</table>

Participants and procedure
Characteristics of the participants in the studies are presented in Table 2.

Table 2
Characteristics of the participants

<table>
<thead>
<tr>
<th>Paper</th>
<th>Participants</th>
<th>Number</th>
<th>Sex</th>
<th>Age, years</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Older people who are recovering from hip fracture surgery</td>
<td>13</td>
<td>Female=7</td>
<td>Md=74</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male=6</td>
<td>Range=66-98</td>
</tr>
<tr>
<td>II</td>
<td>Nurses at an orthopedic unit</td>
<td>18</td>
<td>Female=14</td>
<td>Md=34</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male=4</td>
<td>Range=24-63</td>
</tr>
</tbody>
</table>
**Older people (I)**

A purposive sample of older people (n=13) who lived in a rural area and who had been discharged to home from an orthopedic unit within the last three to five weeks following hip fracture surgery participated in the study. Eight of the participants lived alone and five with a partner or spouse. Eight of the participants had a history of cardio-vascular diseases, and eight had had surgery before. Prior to the hip fracture, four of the participants used walking aids, and two received help from municipal social services. They had been admitted to the unit for approximately 6-21 days before discharge. Purposive sampling means that the people who are invited to participate have experience of a certain topic of interest and therefore can provide rich information and answer the aim of the study (Patton, 2015). To be included in the study, each participant had to be a Swedish speaking person, 65 years of age or older, and had undergone hip fracture surgery. Furthermore, she/he had to be oriented cognitively to their person, time, space, and situation and willing to tell his/her story. Finally, the participants had to be discharged from the hospital to their own home in a rural area.

The recruitment of participants took place at an orthopedic unit. The head of the orthopedic unit gave his consent to let the nurses at the unit take part in recruitment. I informed the nurses about the study. Patients who met the inclusion criteria received oral and written information about the study from the nurses at the orthopedic unit on the day of discharge so that they could give their consent for the research team to contact them at home for further information. I collected the contact information at the hospital, and a few weeks later telephoned those who had shown interest in participating to hear if they were still interested and to set a date and time for the interview. Of the 18 people who agreed to be contacted for further information, 13 chose to participate in the study. All interviews took place in the older people’s homes.

**Nurses (II)**

A purposive sample of nurses (n=18) working in an orthopedic unit participated in the study. The criteria for participation were that the nurses had worked at the orthopedic unit for at least six months and had experience with discharge planning for older patients who had undergone hip fracture surgery. The participants had worked at the unit for 1-28 years (md = 3). The head of the orthopedic unit at the hospital approved the study. The participants were recruited at a nurse meeting where I provided them with
oral and written information about the study in order for them to give their informed consent to participate. A few weeks later, I mediated contact with those interested in participating to set a date and time for the interview. Since nurses could participate during working hours, the focus group interviews took place in a separate room at the nurses’ workplace and were planned to accommodate their schedules.

Data collection methods

**Individual qualitative interviews (I)**

Data were collected with individual qualitative interviews (n=13). The qualitative research interview attempts to describe and understand the meanings of central themes in the world of the subjects (Kvale & Brinkmann, 2014). Individual qualitative interviews allow us to enter the other person’s perspective by capturing their experiences and beliefs. The starting point for qualitative interviewing is the assumption that the perspective of others is meaningful and knowable and can be made explicit (Patton, 2015). It is an interview where knowledge is constructed through interaction between the interviewer and the interviewee. An interview can be seen as an exchange of opinions between two people talking about a theme of mutual interest (Kvale & Brinkmann, 2014). A semi-structured interview guide with open-ended questions was used to ensure that the questions or topics of interest to the study were discussed with each participant. According to Patton (2015), the guide provides topics or subject areas within which the interviewer is free to explore, probe, and ask questions that will illuminate and elucidate that particular subject. Thus, I, as the interviewer, remain free to build a conversation, to word questions spontaneously, and to establish a conversational style but with the focus on a particular subject that has been predetermined (cf. Patton, 2015).

The interviews focused on the older peoples’ experiences of the fall, their health, and wellbeing. In the opening question, the participants were asked to tell about the experience of the fall. After that, they were asked about how their life is now and how their life used to be prior to the hip fracture. They were also asked to tell about the hospital stay, and their level of participation in discharge planning. Probing questions like “can you tell me more about that”, “how did that make you feel” and “can you explain this a little bit further” were asked when clarification was needed. The interviews took place
in the participant’s home in accordance to their wishes and were conducted approximately three to five weeks after discharge. Two participants had their spouses present during the interviews. The interviews were recorded digitally, lasted between 32 and 128 minutes (md= 59), and were transcribed verbatim.

Focus group interviews (II)

Data was collected with focus group interviews (n=4). A focus group interview is a special type of interview with the purpose of obtaining people’s perceptions or views on a defined area of interest in a permissive, nonthreatening environment. The participants are selected because they have certain characteristics in common that relate to the topic of the focus group (Krueger & Casey, 2014). Focus group interviews facilitate interactions among the participants, which, in turn, may enhance data quality since a variety of perspectives may emerge (Patton, 2015). Focus group interviews are suitable in cases where the topic of interest is not of a sensitive matter (Krueger & Casey, 2014).

Five nurses participated in each of the first two focus group interviews, and then four nurses participated in each of the last two, for a total of 18 nurses across all four groups. Group size is essential to the success of focus group interviews but there is no consensus regarding the ideal size. According to Krueger and Casey (2014), the ideal size of a focus group is six to eight participants but with four to six participants, in-depth insights on people’s perceptions are more likely to emerge.

The focus group interviews took place in a separate room at the nurses’ work place. We were seated so that everyone could have eye contact with each other. The focus group interview began with me repeating the information about the study’s aim that was provided at a nurse meeting prior to them leaving their informed consent to participate. In each of the four focus group interviews, I functioned as the moderator, while one of my two supervisors acted as an observer. According to Krueger and Casey (2014), the role of the moderator is to guide the participants through the interview, while that of the observer involves taking notes.
To stimulate the discussion, I presented a vignette (cf. Hughes & Huby, 2002) at the beginning of each interview. A vignette can be a valuable research tool in the study of people’s attitudes, perceptions, and beliefs (Hughes & Huby, 2002). The vignette used in this study described the fictional case of an older woman who lived alone in a rural area and was admitted with a hip fracture to an orthopedic unit (see Table 3 for a summary of the vignette). In the opening question, the participants were asked to tell how they would plan discharge for this patient. Following the description of the vignette, the focus group interviews focused on the nurses’ views on hospital care for older people who suffer a hip fracture, including discharge planning for patients who are discharged home while living in a rural area. The nurses were also asked about patient and family participation in discharge planning. At the end of each focus group interview, I summarized the discussion in front of the participants to ensure that it was accurately perceived. After each focus group interview, my supervisor and I discussed the notes that were taken. The focus group interviews were digitally recorded, lasted between 63-90 minutes (md=78), and transcribed verbatim.

Table 3
Summary of the vignette

Kerstin is a 75-year-old widow who sustained a hip fracture due to a fall when riding her bike. She undergoes hemiarthroplasty surgery and is admitted to the orthopedic unit afterwards. Her medical history includes hypertension and a well-adjusted diabetes type I that she manages by herself. She lives alone in a house with several floors, with the bedroom and bathroom on separate floors. There is no grocery store in the village where she lives, and since Kerstin do not have a driver’s license, a neighbor lets her go with her once a week to shop. She has good contact with her two grown up children who live in the southern part of Sweden.

A couple of days after surgery, Kerstin has started to mobilize and manages visits to the toilet as well as dressing almost independently. However, she is nervous about falling again and does not dare to do things without having staff present. She thinks a lot about how she will manage when she returns home.
Data analysis method

Qualitative content analysis (I, II)

Qualitative content analysis has been used in both studies to analyze the verbatim transcribed interviews. The first descriptions of content analysis were developed for a quantitative approach of counting or measuring similar statements but have developed into an interpretative approach (Graneheim, Lindgren, & Lundman, 2017). Qualitative content analysis is a purpose-driven method for reducing data by making sense of a volume of qualitative material (Patton, 2015). The aim is to attain a condensed and broad description of the phenomenon of interest, and the outcome of the analysis is presented as categories or themes depending on the level of interpretation (Catanzaro, 1988).

The analysis was performed stepwise together with my supervisors, guided by Catanzaro’s (1988) procedure. We began the analysis by reading through the texts several times in order to get an overall picture of its content. In the next step, the text was divided into meaning units related to the aim of this study. A meaning unit refers to the smallest unit that contains some understanding that the investigator needs and may be as small as a sentence or as large as a paragraph. The meaning units were then condensed carefully to avoid losing relevant content and sorted into categories and themes based on similarities and differences in content. Categories can be described as baskets of similar content while themes are seen as threads of meaning that occur in category after category (Catanzaro, 1988). All steps in the analysis process have been systematically documented. Interpretations were discussed until consensus was obtained.

Ethical permission and considerations

This research was conducted in accordance with the declaration of Helsinki (1964), which promotes respect for all human beings and protects their health and rights (World Medical Association, 2001). The studies in this licentiate thesis have been approved by the Regional Ethical Review Board in Umeå, Sweden (DNR no. 2016-154-31). The participants in both studies had received oral and written information about the study before giving their voluntary informed consent to participate. They had also been informed that they can withdraw from the study at any time without giving a reason. According to
Polit and Beck (2016), prospective participants should be informed about the aim of the study, who is conducting the study, what it means to participate, and how data will be handled and protected, all in order to be able to consent or decline participation. For both studies, data have been obtained through interviews: individual qualitative interviews in study I and focus group interviews in study II. The participants have been guaranteed confidentiality and an anonymous presentation of the findings. Confidentiality means that any information participants provide will not be publicly reported in a manner that identifies them and will not be accessible to others (Polit & Beck, 2016).

Findings

The findings from the two papers are presented separately. An overview of themes and categories are presented in Table 4.

Table 4

*Overview of themes and categories*

<table>
<thead>
<tr>
<th>Paper</th>
<th>Themes</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>An unexpected life-altering event</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preparing to return home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Needing adjustment and support at home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Struggling to manage at home</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>A spider in a broken web</td>
<td>Being supportive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involving relatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not always focusing on patients’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difficulties to influence</td>
</tr>
</tbody>
</table>
The study presented in this paper describes older peoples’ experiences of recovery at the hospital as well as returning to their home in rural areas after hip fracture surgery. After the hip fracture, the older people described finding themselves in a new and vulnerable situation, dependent on others for simple everyday chores. They struggled to regain independence while staying positive, convinced that they would recover. Fear of another fall, as well as lack of information, made recovery at home somewhat difficult (i.e., the four themes: an unexpected life-altering event, preparing to return home, needing adjustment and support at home, and struggling to manage at home).

An unexpected life-altering event was related to the older people’s experiences of being affected by a hip fracture. They saw it as an unforeseen event that happened in a second, for which they could not prepare. The older people blamed themselves for the fall and believed that had they done things differently they would not have fallen. Some said they instantly knew they had broken their hip in the fall because of the intensity of pain and not being able to move. Others thought they had simply pulled a muscle and expected it to improve at home in a few days. When that did not occur, they faced reality and went to the hospital for treatment. An unexpected life-altering event also involved the worry and anxiety that the older people who had fallen when they were alone experienced regarding the uncertainty about how long it would take before someone would come look for them.

Preparing to return home was related to the older people’s experiences of their hospital stay. The older people found themselves in a new situation, dependent on healthcare personnel for simple activities in daily life. They acknowledged they needed help but were not overjoyed about it. The older people were aware they needed to put in energy and hard work to recover. They appreciated the help they received and perceived the healthcare personnel as kind, helpful, and supportive, guiding them through this new situation. However, the older people did not feel they had much influence over what happened at the hospital regarding mobilization, training with the physiotherapist, and deciding if and what kind of help they needed at home.
They did not feel they participated in decisions concerning themselves and their care.

_Needing adjustment and support at home_ was related to the older people’s experiences of receiving the aids of assistance and the support they needed for them to manage at home. It felt good to come home and the older people were grateful towards the nature of their home that allowed them to return. They made changes in their home so it would be manageable for them to get around and became adjusted to using aids of assistance and walking aids. The older people felt the support they had gotten from the people close to them - family, friends, neighbors, and social services - had been significant in their returning home and said that it would not have worked out without them. They came to realize they needed to ask for help, but found it somewhat difficult since they were not accustomed to doing things like that.

_Struggling to manage at home_ was related to the older people’s experience of trying to manage the activities of daily life when they returned home. They said it had been difficult in the beginning, but with time it had become easier. The older people felt they were recovering, but some wanted it to go faster; however, they had not received information about the recovery timeline, so they did not know what to expect. Those people started to worry and thought the hip was not mending the way it was supposed to. The older people said they had become afraid that they might fall again, which affected their daily life in terms of not wanting to walk outside or without their walking aid. The fall also had an impact on how they looked at their life and future; they were confident and optimistic they would recover, while at the same time realizing they were not getting any younger and their health could quickly change.

Paper II – The perspective of nurses working at the orthopedic unit

_A spider in a broken web: nurses’ views on discharge planning for older patients after hip fracture surgery who live in their own homes in rural areas_

The study presented in this paper describes nurses’ views on discharge planning with older hip fracture patients who live in rural areas. This study
shows that nurses believed that patients need support from healthcare personnel as well as relatives to prepare for a life at home. Nurses expressed that they and the patients had difficulties influencing many aspects surrounding discharge planning (i.e., the theme a spider in a broken web was constructed from the four categories: being supportive, involving relatives, not always focusing on patients’ needs, and difficulties to influence).

*Being supportive* was related to nurses’ views on the importance of supporting and strengthening the patient’s autonomy as much as possible before discharge. The nurses considered the patients with a hip fracture to be strong, independent individuals who could have trouble accepting they were now dependent on others for simple everyday chores and they addressed the issue of possibly needing help after discharge early during the hospital stay. They described that they encouraged the patients to do as much as possible themselves during the hospital stay while cheering them on, but admitted that it was sometimes difficult due to lack of time. The nurses underscored the importance of the patient receiving information according to their individual need and wanted more information to be in writing, since it could be difficult for the patient to remember everything they had talked about in the hospital.

*Involving relatives* was related to nurses’ views that the patient’s relatives were important throughout discharge planning, even if the relatives were sometimes perceived as unreasonably demanding or controlling. They emphasized that most relatives were helpful and unselfish in terms of taking time off from work to stay with their older relative to support them after discharge from hospital. The nurses received information from the relatives regarding the patient’s home conditions and their ability to manage at home with the amount of support the patient had prior to the hip fracture. Sometimes the relatives disagreed with what the patient wanted and, in those cases, the relationships between them became tense. The nurses described mediating, but ultimately felt obligated to support the patient’s point of view. Given the importance of relatives to patients after hip fracture surgery, nurses worried for patients who did not have relatives.

*Not always focusing on patients’ needs* was related to nurses’ concerns about the patient’s difficulties in participating in decisions regarding discharge planning. They felt the municipal discharge planning team made decisions in advance and the meeting was considered merely a formality in which patients
had little to no ability to affect the outcome. The nurses experienced that patients could have trouble getting their voices heard at the meetings due to the large number of participants. They said that patients sometimes questioned their own presence at the meeting since no one seemed to pay attention to their opinions. The nurses wished for a more flexible discharge planning that took the needs and concerns for each individual into consideration when planning care. They speculated about having a social worker from the hospital attending the municipal discharge-planning meeting to advocate for patients who were perceived as quiet and modest or did not have relatives present at the meeting.

Difficulties to influence was related to the nurses’ view that they had little ability to influence discharge planning. Collaboration between healthcare personnel had changed during the last couple of years, which had resulted in people becoming reluctant to help each other, both within and outside their own organization. This change negatively impacted discharge planning. Nurses also described struggling to accept a patient’s decision to decline municipal social services when it collided with the nurses’ own strong belief that the patient would have trouble managing on their own. They tried their best to persuade the patient to change their mind, but in the end they had to accept the patient’s decision. The nurses said that they assumed things worked out well for the patient at home, but since they did not receive feedback they could not be certain. Sometimes nurses took the initiative to perform informal follow-ups by calling the patient to check if everything was all right in order to ease their anxiety. However, they realized that they did not have resources to do this routinely.

Discussion

The overall aim of this licentiate thesis was to describe recovery after a hip fracture for older people living in rural areas, i.e., the process of transition in daily life and the planning for return to home from the hospital. The findings in this study will be linked to the theory of transition (Meleis, 2010) and to prior research. According to Meleis (2010), a transition can be described as a period between two relatively stable periods in life. This licentiate thesis shows the importance of older people being able to participate in their own care as well as receiving support and information during recovery after a hip fracture (I, II). Since recovery begins at the hospital, the nurses at the
The older people in this study found themselves in a new situation after the fall: they were dependent on others for simple, daily activities, a situation they did not enjoy but had to accept and manage (I). The nurses at the orthopedic unit were attentive of patients’ feelings of awkwardness of needing help and did their best to support the rebuilding of their independence (II). When a person experiences a change in health and illness, such as a hip fracture, the process of transition begins. Nurses tend to be the caregivers who prepare patients for transitions and who facilitate the process of learning new skills related to the patients’ health and illness experiences (Meleis, 2010). Nursing care builds upon encounters, relations, perceptiveness, and openness toward the patients’ needs and an awareness of their own vulnerability (Rydeman, Törnkvist, Agreus, & Dahlberg, 2012). Nurses need to treat older people with respect for their experiences in order for them to feel heard, seen, and included, which, in turn, could lead to feelings of trust and safety. Patients must be confirmed in their changes in daily life. The nurses said that they encouraged the patients to manage as much of their daily activities as possible while letting them know they were doing great (II). Gesar, Hommel et al. (2017) found that when older patients recovering from hip fracture surgery adapt to a new situation, they need confirmation. To hear that they were doing well had a positive influence on their self-confidence. To be confirmed seems to be an important part of recovery and, for the older people in this study, this could help develop confidence which, according to Meleis (2010), is a facilitator for a healthy transition.

The older people described that they felt well-taken care of during the hospital stay but they did not feel that the care and the information they were given were adjusted according to their individual needs. Instead, they perceived that things were done rather routinely (I). The older people’s experience conflicted with that of the nurses, who emphasized the importance of patients being individuals and said that information about care was given according to the individual’s need (II). According to Suhonen and Leino-Kilpi (2012), it is important for older patients at an orthopedic unit to be cared for as individuals rather than simply as “a patient with a hip fracture,” and they need to feel that their personal life situation is supported and taken into account in their care. The discrepancy between the older people’s and nurse’s experiences about the level of individualized care given implies that the
nurses failed to make the patient feel that the care and information were adjusted according to their needs. This was apparent since some of the patients did not understand why they had to learn how to climb stairs before leaving the hospital when they did not have them at home (I). To help patients understand the purpose of activities that can appear unnecessary to them seems pivotal in nursing care for older patients recovering from hip fracture surgery. Hence, nurses need to prompt their patients to become independent and explain why it is important to do certain things.

Providing the patient with knowledge of why one does things helps them to understand and to become willing to undertake specific activities (Meleis, 2010; Tobiano, Bucknall, Marshall, Guinane, & Chaboyer, 2015). According to Meleis (2010), a patient’s involvement and engagement in seeking out information as well as actively preparing and modifying activities are a part of the transition process. In accordance to this, nurses need to make the patient aware of the benefits of practicing climbing stairs in the safe environment at the hospital, guided by a professional physiotherapist. Not knowing how to or feeling uncertain about how to climb stairs when discharged could potentially lead to avoidance of such activities. This is in line with Zidén, Wenestam, and Hansson-Scherman’s (2008) findings, who showed that older people can feel isolated and trapped at home when they find everyday activities difficult, such as being able to move and walk freely, as often happens after hip fracture surgery.

The findings show that the older people expressed that they had difficulties in knowing what help was available to them during the meeting with the municipal discharge planning team and, for that reason, simply agreed to what the team suggested (I). This indicates that the older people did not receive enough information about the municipal social service prior to the meeting nor at the meeting for them to be able to participate in decisions regarding post-discharge care. Not having enough information could relate to the older person’s lack of essential knowledge about discharge planning and the conditions for further care (Efraimsson, Sandman, & Rasmussen, 2006). It would seem appropriate that nurses at the hospital have the responsibility to inform their patients, since nurses, according to Rhudy et al. (2010), consider themselves as the people who coordinate discharge planning. However, the nurses stated that a well-informed patient manages better at home (II), so it is reasonable to believe that they provided the patients with information regarding the care that the municipal social service can offer at
home, but the patients had trouble remembering it among all other information and activities during the short hospital stay. A study by Dyrstad et al. (2015) showed that patients could have difficulties remembering information that has been given to them during the hospital stay due to confusion, tiredness, and anxiety about their medical condition. One must not forget either that the older people in this study had just experienced a traumatic life-altering event that could have affected how they processed information given to them. According to Meleis (2010), patients in transitions can be vulnerable. Nurses need to identify indicators that move patients either in the direction of health or toward vulnerability and risk and make assessments and interventions to facilitate a healthy outcome.

The nurses in this study acknowledged that it could be difficult for the patient to remember everything that had been talked about. To enhance the patients’ possibilities to stay informed, the nurses wanted more information to be in writing (II). It is also possible that the somewhat complicated relations between the nurses at the hospital and the discharge planning team from the municipality affected what information was provided to the older people. Maybe the nurses felt uncertain about which information to give due to their perceptions of no power to influence the outcome of the meeting (II). This assumption is supported by Augustinsson and Petersson (2015), whose findings showed that the nurses at the hospital had been told that they were not allowed to tell the patient what help she/he would get at home since that decision was to be made after an assessment by the social worker from the municipality.

The older people expressed that they were convinced that it was important to stay positive during recovery and that they were convinced that they would recover (I). This is in line with the findings from Young and Resnick (2009), whose participants emphasized the importance of having a positive attitude and self-determination during recovery. However, some of the older people in this study had become impatient and started to think that something was not right, since they were not recovering at the pace they had anticipated (I). Gesar, Bååth et al. (2017) found that when recovery is perceived as slower than expected, the older people start to have doubts that they will recover and find themselves considering whether to continue to fight for independence or to give up. Given the importance of staying positive during recovery, it would seem crucial that patients receive information about what to expect regarding recovery timeline and milestones. According to Meleis (2010), knowledge
about what to expect during a transition may be helpful for managing it. Since recovering from hip fracture surgery takes time, and changes are not visible on a day-to-day basis, Schiller et al. (2015) found that keeping a diary that would illuminate the process over time was helpful. Despite the benefits of information about the hip fracture and recovery, several studies describe older people’s general lack of adequate knowledge, which makes it difficult for them to assess whether their progress is normal or not (Forsberg et al., 2014; Olsson, Nyström, Karlsson, & Ekman, 2007).

The rural context in this study seemed to affect neither the older people’s experiences of recovery (I) nor the nurse’s views on discharge planning (II). This was a bit surprising since living in rural areas has been described as rather difficult for older people, who often have complex health issues (Scharf et al., 2016), and due to the lack of specialized health care (Hanlon & Kearns, 2016). The older people in this study were grateful that they had been able to return home and spoke highly of the people in their neighborhood in terms of their support and willingness to help each other out (I). A prominent theme in transition narratives describes the need to feel and stay connected. This could, for instance, mean making new contacts and continuing old connections with extended family and friends (Meleis, 2010). The older people, however, spoke of uncertainty related to potential future falls: in such a case, they knew that they could end up lying on the ground for a long time, since not many people passed their house each day (I). The helplessness and worry of falling when alone and laying on the ground for hours waiting for help has previously been described by Roe et al. (2008) and Jellesmark et al. (2012). This implies that this concern is just as big for people who live in a city as it is for those who live in a rural area. Perhaps this is connected to the physical impairment that follows a hip fracture rather than the rural area.

The nurses spoke about the older homes where many of the patients resided, acknowledging that they were often unpractical since bathrooms and bedrooms often were situated on different floors, which meant that the older person would have to manage climbing stairs. The nurses believed that with the right type of aids, for instance a mobile toilet at home and a temporary move of furniture, that would not have to be a problem (II). Those beliefs are supported by the older people who said that they had refurnished and temporarily made a laundry room into a shower (I) as well as by Randström, Asplund and Svedlund’s (2012), findings who showed that the accessibility of residential buildings affects the older people’s ability to perform activities at
home. For people whose homes were not designed to accommodate a physical impairment, some modifications were necessary, for instance the construction of an indoor ramp to facilitate moving around in a wheelchair.

**Methodological considerations**

Trustworthiness is a term used in qualitative research that aims at persuading the reader that the findings of an inquiry are worth paying attention to and that involves the concepts of credibility, dependability, confirmability, and transferability and can be done in many different ways (Lincoln & Guba, 1985). In this licentiates thesis, issues of trustworthiness have been kept in mind throughout the entire research process, from the beginning when planning the studies all the way to the reporting of the findings (cf. Graneheim et al., 2017).

One way to establish credibility is to choose the most suitable data collection method for the study. For the study presented in Paper I, individual interviews were considered the most suitable data collection method. Had we used focus group interviews, it is likely that the participants would not have felt comfortable sharing their experiences since they were quite personal. In the study presented in Paper II, focus group interviews was considered a suitable method since the aim of the study was to describe nurses’ views on discharge planning for older patients after hip fracture surgery who live in their own homes in rural areas. The participants shared their views in a familiar and permissive environment without any participants being dominant, which allowed for contrasting opinions. Another way to establish credibility in this study was that all the authors were involved with the data analysis and interpretations were discussed until consensus was obtained. In addition, quotations from the interviews have been used to help the reader to judge whether our interpretations are credible.

As a way of establishing dependability, interview guides have been used in both studies to ensure that all participants were asked about the same topics. The fact that the interview guides (I, II) had not been tested prior to the first interviews can be seen as a limitation. However, the guides turned out to be comprehensible by the participants in study I as well as the participants in study II. Hence, we (the research team) decided to use them without making
alterations. To further establish dependability, all individual interviews as well as the focus group interviews have been conducted by me.

To establish confirmability, the participants were chosen by purposive sampling, which aims at recruiting participants that had experience with the phenomenon of interest. Recruiting information-rich participants provides insight and in-depth understanding. The number of participants in both studies (n=13, n=18) can be considered a rather small sample size. However, the sample size for both studies in this thesis was guided by Malterud, Siersma, and Guassora’s (2016) concept of information power: the more information the sample holds, the fewer participants are required. Thus, sample suitability and data quality are more important than the number of participants in this context. The interviews were rich in content and contained variation, differences, and similarities among the older people’s experiences of recovering from hip fracture surgery as well as among the nurses’ views on discharge planning.

In order for the reader to make judgements regarding transferability, my/our ambition has been to make the clearest descriptions of the participants and the context as possible without risking revealing confidentiality or anonymity (cf. Graneheim et al., 2017). The findings can be transferred to similar situations if they are decontextualized from the current context (Polit & Beck, 2016).

In qualitative research, the researcher is the instrument. The researcher’s background, experience, education, and the way she/he engages in data collection and analysis affect the trustworthiness of the findings (Patton, 2015). Hence, reflection on how my data collection and interpretation are affected by who I am, what is going on in my life, how I view the world, and how I have chosen to study what interests me is a part of the qualitative methodology. I have several years of experience in orthopedic nursing, and I consider that to be a strength since that gives me an insider perspective (cf. Patton, 2015). However, it can also be a limitation if I let my preunderstanding stand in the way of the research process. Since my preunderstanding is pivotal, it has been my intention to put it aside to prevent it from affecting the material.
Conclusion

This licentiate thesis focuses on older people’s experiences of recovering from hip fracture surgery in their own home in a rural area as well as nurses’ views on discharge planning for these patients. It shows that each experience of recovery is unique, complex, and multidimensional. Self-determination, a positive attitude, and support from healthcare personnel as well as from family and friends play significant roles in reaching optimal recovery.

Suffering an acute life-altering event such as a hip fracture has great impact on the affected person’s daily life. However, it seems that they have rather few opportunities to participate in and influence decision making during discharge planning. The findings show that that the person affected by a hip fracture is not as participative as she/he would need to be in this rather extensive, time-consuming period of transition in order to take the day for granted again. The experiences of recovery from hip fracture are unique in a rather standardized healthcare environment. According to Meleis (2010), a healthy completion of a transition is determined by the extent to which individuals demonstrate mastery of the new skills and behaviors needed to manage their new situation, i.e., when they are experiencing a new sense of stability. To support and facilitate a healthy transition, healthcare personnel need to see the individual and find out what is important for them and provide sufficient information in order for the older people to participate in discharge planning.

The findings also show that while the older people were hospitalized, they felt supported by the staff, whereas when they returned home, they lacked information about what was going to happen regarding recovery timeline and follow up visits to the doctor. This means that although family members were there to support activities in daily life, the older people continued to need support in the form of information from healthcare personnel after discharge. If follow up calls were made routinely, the older people would be able to feel safer at discharge knowing that someone would contact them and to answer questions that might have risen since they returned home. This, together with coherent written information prior to discharge, could lead to improved care for people after hip fracture surgery since the nurses would receive feedback from the patients about what worked and what can be done differently.
How older people experience recovery after hip fracture surgery or how nurses plan discharge does not seem to be affected by the rural context in this study. What seemed to be most important to the older people was the fact that they had been able to return to their own home after discharge. For the nurses, a lack of support systems around the patient was of greater concern than the geographic location of the patient’s home. This however calls for further research.
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